

common SENSE



when minutes count

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PRESIDENT'S MESSAGE

Making Cents of Overcrowding

by Tom Scaletta, MD FAAEM

The Institute of Medicine (IOM) released "The Future of Emergency Care in the United States Health System" this past summer, emphasizing the degree of patient overcrowding we are experiencing. The U.S. Department of Health and Human Services published a related report on September 28, 2006, stating that up to half of emergency departments experienced overcrowding in 2003 and 2004, defined in part as when urgent patients wait more than an hour. Both studies overlooked an important cause of overcrowding, intentional understaffing of emergency physicians by emergency services contract holders.

Understaffing is a typical consequence of fee-splitting, a common emergency medicine practice whereby the contract owner takes an excessive portion of the revenue generated from physician fees, well beyond fair market value for management expenses and overhead. Simply stated, corporate profit is derived from physician fees. By eliminating fee-splitting from the cycle of emergency patient care, more resources can be focused on care delivery at essentially no additional cost to the general public.

When you analyze how each dollar of revenue for an emergency physician group is spent, roughly 70 cents goes toward clinical salary, a composite of hourly wage and staffing levels. The next largest portion, about 12 cents, goes toward professional liability insurance. This amount is relatively fixed by market rates with some regional variability. In states without caps and high award amounts, this number increases and salary commensurately decreases. The next portion, about 8 cents, pays for coding, billing and collecting, which is also fixed by market rates with some regional variability. In my opinion, a healthy amount for administration and practice management is 10% of clinical salary, so 7 cents. Only 3 cents covers all other business expenses.

With this simple accounting model in mind, think of fee-splitting as an attempt to squeeze out a nickel or dime. In a setting with closed books, the cost of liability insurance or coding, billing and collecting can be exaggerated. More commonly however, the profit margin is "created" by a reduction in clinical salary. To secure good emergency physicians, the hourly rate must be competitive so decreased staffing levels is more prevalent. If the number of patients per physician per hour (PPH) were at two and a half, the recommended maximum for a comprehensive emergency department, a 10 cent carve out increases the PPH to about three and worsens overcrowding, with increased waits, cursory evaluations and too many handoffs to the oncoming physician.

Hard evidence of fee-splitting exists. For example, EmCare, a large provider of emergency physician services, with 329 contracts in 39 states, is responsible for over 5 million annual patient visits and employs 4,500 physicians. The primary revenue source is emergency physician fees, and the total compensation of its non-physician CEO reported in 2005 was \$23M. This particular corporation, responsible for a large portion of the emergency medicine "safety net," is owned by venture capitalists.

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The following passage is found in EmCare's 2005 SEC filing. "Regulatory authorities or other parties, including our affiliated physicians, may assert that, we are engaged in the corporate practice of medicine or that our contractual arrangements with affiliated physician groups constitute unlawful fee-splitting. In this event, we could be subject to adverse judicial or administrative interpretations, to civil or criminal penalties, our contracts could be found legally invalid and unenforceable or we could be required to restructure our contractual arrangements with our affiliated physician groups."

To repair the frayed emergency medicine safety net, profit derived from fee-splitting must be reclaimed and used to fortify emergency physician staffing levels, the primary factor in patient safety. The federal government must enforce existing laws prohibiting fee-splitting and hold those contract management groups accountable. AAEM is working to focus the political spotlight on this tax-free solution to emergency department overcrowding.



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AAEM Mission Statement

The American Academy of Emergency Medicine (AAEM) is the specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine, and to ensure a high quality of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.

Membership Information

Fellow and Full Voting Member: \$365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
Emeritus Member: \$250 (Must 65 years old and a full voting member in good standing for 3 years)
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EDITOR'S LETTER

"Participate or Perish"

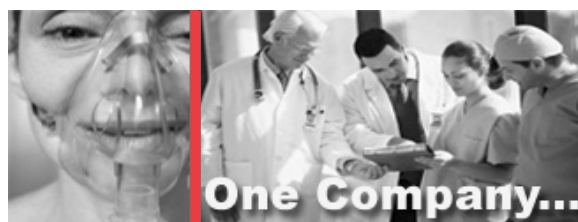
by David Kramer, MD FAAEM

Well, it is that time of year again. Residency recruitment season is in high gear, and program directors across the country are working hard to recruit the best and the brightest to their residency programs. Every one of us in residency leadership positions is committed to training the highest quality emergency physicians in order to provide the best emergency care for our patients. Part and parcel of this is our concern for our residents' career choices. We want them to have satisfying careers in situations where they are valued for the work they do. Many of the longstanding initiatives of AAEM help ensure that these goals are met. Still, all of us have had residents who have taken less than ideal positions due to geographic or other needs.

In other words, there is much more to be done. I know that I am preaching to the choir here, but emergency medicine needs you more than ever. We need more than your membership; we need your participation. There are growing opportunities within our organization for you to participate and contribute. I'm not here to minimize the importance of your membership dollars. Supporting the individual emergency physician does cost money. But we also need your time and energy. While many of you do contribute in various ways, others do not. I'm reminded of a hackneyed but applicable quote: "If you're not part of the solution, you're part of the problem." While I certainly don't want you to take this quote literally, I do believe that one can accomplish much more by doing than by observing. Although I respect those that come to me with problems, I value much more those that also come with proposed solutions. The success of an organization is dependent on the activity and productivity of its members.

So, what options are there for contributing to our organization? Three opportunities come immediately to mind. First, AAEM has more committees than you can shake a stick at. Certainly one or more would tweak your interest. Second, many of you are eligible for membership in the new Young Physicians Section (YPS). The YPS developed from Dr. David Vega's desire for AAEM to do more for those starting out in practice while simultaneously providing an opportunity for the development of leadership skills. You can get in on the ground floor and help develop and grow this section. Finally, leadership positions will be voted on at the next Scientific Assembly. Remember that self nominations are welcome. Some of you might have new and innovative ideas. Feel free to e-mail them to me at CSeditor@aaem.org. I will be sure to pass them on to the AAEM board of directors.

This brings me to Las Vegas. Our annual Scientific Assembly will be here before you know it. My wife and I just returned from a vacation in Vegas (it was a true vacation-no kids) where we had a great time. I am confident that all attendees at our Scientific Assembly will return home with great memories and stories to tell (or not to tell). I encourage you to not only plan to attend, but also check out the entertainment options early as popular shows, concerts and artists tend to sell out quickly. It's our 13th Annual Scientific Assembly, March 12-14, 2007. See you in Vegas!



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AAEM Congratulates Carey Chisholm, MD FAAEM

Dr. Chisholm, program director at Indiana University School of Medicine, is one of ten program directors who received the ACGME 2007 Parker J. Palmer Courage to Teach Award. Their specialties vary, but the ten residency program directors selected for the ACGME's Parker J. Palmer Courage to Teach Award share the same qualities: a dedication to teaching new doctors and a talent for creating innovative and effective residency programs. The program directors will be honored February 12, 2007, at an awards dinner held during the ACGME's winter Board of Directors meeting in Rosemont, Illinois.



Book Award

Drs. SV Mahadevan and GM Garmel received the 2006 American Medical Writer's Association Book Award, Physician Category for their textbook, *An Introduction to Clinical Emergency Medicine: Guide to Practitioners in the Emergency Department* (Cambridge Univ Press, 2005). They were presented this national award in Albuquerque, NM (October 27, 2006).



Readers Response to President's Message in September/October Issue

Hello!

I recently read your president's message in *Common Sense* regarding Certification in Emergency Nursing. It was a great article and thank you so much for supporting certification. It really is that mark of acquiring the core competency level in emergency nursing - a goal for all emergency nurses. And you are exactly right that physician and administrative support for the education, preparation for exam, exam itself and then pay differentiation for those who have achieved it are all key support points to encourage more emergency nurses to pursue certification.

I really commend you on choosing this topic to push forward to your peers...

Have a great day!
Mary Jagim

Mary Jagim, RN BSN CEN FAEN
Internal Consultant for Pandemic and Emergency
Preparedness
Past-President Emergency Nurses Association

Dear Tom,

The Board of Certification for Emergency Nursing and the Emergency Nurses Association sends a hearty thank you to you and the American Academy of Emergency Medicine for your article on CEN. Thank you and the AAEM for your support of CEN. We will probably be contacting you soon to get AAEM's permission to re-run this article in the ENA Connection.

Take Care

Tancy Stanbery, MEd
Certification Officer
Board of Certification for Emergency Nursing (BCEN)
915 Lee St.
Des Plaines, IL 60016-6569

First Site Designated as Emergency Department with Workplace Fairness

The American Academy of Emergency Medicine (AAEM) announced that the UCI Medical Center in Orange, CA, is the first in the nation to be designated as an Emergency Department with Workplace Fairness.

This fall, the AAEM board of directors approved changes of the emergency department standards for employment excellence. AAEM will certify excellence in the ED workplace if emergency department physician employees are guaranteed the following five workplace conditions:

- A reasonable due process policy.
- A reasonable policy of financial transparency that protects physicians against financial exploitation.
- A reasonable policy of financial equity that allows physicians to share in the department's profits.
- A reasonable policy of political equity that allows physicians to improve their own working conditions.
- Employment arrangements that do not impose post-contractual restrictions.

The Academy recognizes the existence of many different emergency department business models. The following examples are provided as guidelines that comply with the principles outlined above. These guidelines are not absolute, but reflect the spirit of fairness encouraged by the Academy. Thus, any group that believes it meets conditions for fairness is encouraged to submit an application for a certificate of excellence. The application can be found below or at: <http://www.aaem.org/membership/compliancecert.pdf>. Applications will be reviewed by the Academy. Departments that are deemed to fall outside fairness criteria will be provided direct feedback and given ample opportunity to reapply. Emergency physicians are encouraged to contact AAEM (anonymously if desired) to report a listed group that they believe is not in compliance along with an explanation.

Principle	Examples of fair employment practices
Due process	Unilateral termination without cause and without rights defined in the medical staff bylaws is acceptable only during a provisional period of employment, not to exceed one year. Termination with cause requires a fair hearing upon request of the terminated physician.
Financial transparency	Partners are automatically provided information on total group charges, collections, management, and operational expenses, and other group income distribution on at least a quarterly basis.
Financial equity	For democratic groups, full partnership opportunities are available through a predefined process that does not exceed three years. Share distribution among partners is transparent.
Political equity	Governance procedures are published, with processes for election of leadership and partners, appointment of medical directors and administrators, and bylaws amendments.
Political equity	Practicing physicians must make all practice decisions (including those involving hiring, firing, staffing levels, and clinical processes) and have a primary fiduciary responsibility to their patients, not to a corporate entity or shareholders. No layperson (defined as a non-physician or non-practicing physician) can have a commercial interest in the practice or the right to control the professional judgment of any practicing physician. No layperson may be a corporate officer or director or occupy a position of similar control. Physician employment by hospitals or non-profit entities is permissible when in accordance with state law.
No post-contractual restrictions	Non-compete or similar clauses that affect where a physician may work upon leaving the group or upon group turnover are not conditions of employment.

Become one of the recognized emergency departments designated as an Emergency Department with Workplace Fairness! For more information, contact info@aaem.org or call 800-884-2236. To apply, complete the information below and mail to AAEM at: 555 E. Wells St. Suite 1100, Milwaukee, WI 53202.

Name _____ Date _____

Signature _____ Location _____

Title _____ Email Address _____

☐ I verify that I am a member of AAEM.

Emergency Care Systems Facing Critical Workforce Shortages

by Kathleen Ream, Director of Government Affairs

According to a new study by the Center for Health Workforce Studies (CHWS) at the University at Albany's School of Public Health, emergency care systems in the United States are at serious risk of critical shortages in staffing in the near future. The three key reasons are: an inadequate supply of board certified emergency medicine physicians, the worsening shortages of RNs, and difficulty recruiting and retaining EMTs in rural areas. Meanwhile, the future demand for emergency care services and workers is expected to increase due to issues such as: the potential for bioterrorism or other mass casualty incidents, the aging population and the growing number of uninsured.

The study, entitled *The Emergency Care Workforce in the U.S.*, covered pre-hospital emergency services, EDs in hospitals, freestanding urgent care centers and teams dispatched by local, state or federal governments or volunteer organizations in response to a widespread emergency or disaster. Among the study's key findings are:

- The supply of board certified emergency medicine physicians may not be adequate to meet demand. Nearly 20% of physicians specializing in emergency medicine are working as independent contractors, compared to 4% of all physicians.
- Emergency care services are currently affected by the shortage of RNs. EDs are one of the most common locations for RN openings at hospitals, and this situation will persist as RN shortages worsen.
- The composition of the emergency care workforce varies significantly between rural and urban areas, with fewer emergency medicine physicians in rural areas and fewer ED RNs and physician assistants in urban areas.
- While EMTs are not generally seen as in short supply, the high rate of turnover in rural areas makes the recruitment and retention of EMTs in these areas a continuing concern.

The study can be viewed at www.albany.edu/news/pdf_files/EmergencyCare%20Workforce%20in%20the%20US%2008%2006A.pdf

Federal Court Finds CMS Report Admissible for EMTALA Case

On August 14, 2006, the U.S. District Court for the Middle District of Alabama ruled on a defendant's motion to strike evidence submitted by a plaintiff in opposition to a pending motion for summary judgment. The case involved plaintiff Ginger Henderson who brought suit against Medical Center Enterprise (MCE) (*Henderson v. Medical Center Enterprise, M.D. Ala., No. 1:05 cv 823 MEF, 8/14/06*).

During the afternoon of November 30, 2004, Henderson was involved in an automobile accident. A few hours later, Henderson, who was approximately 38 weeks pregnant, presented at MCE's ED. Allegedly, the ED clerk told Henderson that the clerk would need to contact the on call obstetrician, who then would decide whether or not Henderson would be seen. Henderson decided not to wait and instead traveled to another hospital, where she was seen and admitted for observation.

Henderson claimed a violation of the Emergency Treatment and Active Labor Act (EMTALA). In response to MCE's motion for summary judgment, Henderson submitted a report of an investigative survey of MCE from the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services. The CMS investigation found that MCE's treatment of the plaintiff violated federal regulations, concluding that defendant's Medicare certification would be terminated absent correction of the deficiencies. MCE moved to strike the CMS investigation from the record, believing the "information is inadmissible pursuant to the Federal Rules of Evidence 803(8)(C)." MCE argued that the CMS survey did not fall under Rule 803(8) because it was never made public, and as such, was not a public record. The federal court determined that MCE cited no authority, and the court could find none requiring that information be made public in order for it to qualify as a public record. Thus, the fact that the information "is contained in the records of a public agency, namely Department of Health and Human Services, is sufficient in this case," ruled the court.

MCE further argued that the CMS record does not fall under Rule 803(8) because it lacks trustworthiness owing to the fact that "the citation and action to terminate MCE's Medicare certification were later withdrawn." The court noted that withdrawal of the citation and termination of the action were due to actions that had been taken "to correct the deficiencies that were cited"; and that having been made gave reasonable assurance that a similar violation would not recur. Ergo, reasoned the court, the withdrawal "does not mean that the findings of deficiencies in the earlier report were inaccurate, it simply means that CMS was satisfied that the deficiencies had been sufficiently addressed . . . and the Court does not have any reason to believe that the factual findings set forth in the survey are untrustworthy."

The district court did agree, in part, with MCE's contention that the information should be precluded from admission because it offers legal conclusions. The court found that the portion of the CMS report asserting that MCE violated certain federal regulations in its treatment of Henderson would not be admissible as evidence in this case but that those legal conclusions would not prohibit the court from considering any factual findings made during the CMS investigation. The court also concurred with the defendant that "references to subsequent remedial measures as evidence of culpable conduct by MCE" are inadmissible pursuant to Rule 407.

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Upcoming AAEM-Endorsed or AAEM-Sponsored Conferences for 2006–2007

January 17-21, 2007

- Fifth Annual Western States Winter Conference on Emergency Medicine
During the Sundance Film Festival
Snowbird/Alta Ski Resort, Snowbird, UT
Sponsored by the Emergency Medicine Departments of: Oregon Health and Science University, University of Utah Health Sciences Center, University of California, San Diego Medical Center, University of California, Irvine
Conference website: <http://www.wswcem.com>
For conference registration, please contact Kelsey at klemke@ohsu.edu

January 22-25, 2007

- Best Evidence in Emergency Medicine Course (BEEM)
Silver Star Mountain, British Columbia, Canada
Sponsored and organized by McMaster University, Continuing Health Sciences Education.
<http://www.beemcourse.com/index.html>

January 27-31, 2007

- Rocky Mountain Winter Conference on Emergency Medicine
Copper Mountain, Colorado
Sponsored by Beth Israel Deaconess Medical Center, Boston, MA, Brigham and Women's Hospital, Boston, MA, Denver Health Medical Center, Denver, CO and others. (Please see conference website for complete list of sponsors.)
www.coppercme.com

March 12-14, 2007

- AAEM 13th Annual Scientific Assembly
Caesars Palace, Las Vegas, Nevada
Sponsored by the American Academy of Emergency Medicine
FREE Registration for AAEM Members
<http://www.aaem.org>

April 14-15, 2007

- AAEM Pearls of Wisdom Oral Board Review Course
Chicago, Dallas, Los Angeles, Orlando, Philadelphia
Course sponsored and organized by the American Academy of Emergency Medicine
<http://www.aaem.org>
Registration opens January 17, 2007.

May 13-16, 2007

- 15th World Congress on Disaster and Emergency Medicine
Amsterdam, The Netherlands
Sponsored by the World Association for Disaster and Emergency Medicine
www.wcdem2007.org

May 15, 2007

- A Consensus Conference on Knowledge Translation in Emergency Medicine
'Establishing a Research Agenda and Guide Map for Evidence Uptake'
Sponsored by Academic Emergency Medicine: The official journal of the Society for Academic Emergency Medicine
Chicago, IL
<http://www.saem.org/saemdnn/Meetings/AnnualMeeting/AEMConsensusConference2007/tabid/362/Default.aspx>

May 24-26, 2007

- High Risk Emergency Medicine
Hotel Nikko, San Francisco, CA
Conference sponsored by San Francisco General Hospital and the Department of Emergency Medicine at the University of California, San Francisco
www.HighRiskEM.com

June 28-July 1, 2007

- Giant Steps in Emergency Medicine 2007: The Sun, the Sea...and CME
Sea Crest Oceanfront Resort and Conference Center
North Falmouth (Cape Cod), MA
Conference co-sponsored by Giant Steps in Emergency Medicine and AAEM.
www.GiantSteps-EM.com

September 15-19, 2007

- The Fourth Mediterranean Emergency Medicine Congress
Hilton Sorrento Palace, Sorrento, Italy
Sponsored by the European Society for Emergency Medicine (EuSEM), the American Academy of Emergency Medicine (AAEM) and the Italian Society of Emergency Medicine (SIMEU)
www.emcongress.org

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Tom Derenne to learn more about the AAEM endorsement approval process: tderenne@aaem.org.

All endorsed, supported and sponsored conferences and activities must be approved by AAEM's ACCME Subcommittee.

AAEM Young Physicians Section

PRESIDENT'S MESSAGE

Allowing for Imperfection

by David D. Vega, MD

A friend of mine recently pointed out how frustrated he is by the frequency with which his work is viewed through the fine focus of the retrospectroscope. I have to admit that I can get a little discouraged by this from time to time, too. "Feedback" from consultants, insurance companies, nurses, residents and even our colleagues can be far less than constructive at times. The impact of these criticisms is compounded by the fact that many of us, by nature, are our own harshest critics and put a lot of pressure on ourselves to always be perfect -- despite the fact that this is an impossible goal.

In both our professional and personal lives, we are going to face failures and disappointments. As younger physicians, we need to realize that, as human beings, we are not perfect. When we come to this realization, we will be better set to develop more confidence in our abilities. Setbacks and failures are going to happen, but we must recover and learn from these experiences. Success will come, not as a result of perfection, but as a result of perseverance.

Theodore Roosevelt said, "It is not the critic who counts, not the man who points out how the strong man stumbled, or where the doer of deeds could have done better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly, who errs and comes short again and again, who knows the great enthusiasms, the great devotions, and spends himself in a worthy cause, who at best knows achievement and who at the worst if he fails at least fails while daring greatly so that his place shall never be with those cold and timid souls who know neither victory nor defeat." (From "Citizenship in a Republic," Speech at the Sorbonne, Paris, April 23, 1910,

accessed online at <<http://www.theodoreroosevelt.org/life/quotes.htm>>, October 5, 2006)

Who is in the arena more than the emergency physician? As we stand on the front lines of medicine, we struggle against critical illnesses and social nightmares in the setting of overcrowding, increasing regulation and a medical liability crisis. Critics abound and the small voices of praise can easily be lost in all of the background noise. Nonetheless, we can continue our fight with confidence, knowing that in the end, we are accomplishing good.

I hope that you will see this article as an encouragement and challenge to face adversity in your career and in your life with the knowledge that you are not alone in your struggles. Although the details may change a little, every trial in your life has been faced before by someone else. By seeking out those with similar experiences, we are often able to realize solutions that we might not be able to find on our own. Conversely, by sharing our experiences with our colleagues who are seeking help, we can enjoy greater satisfaction in our careers.

I would invite you to join the Young Physicians Section (YPS) as we tackle issues that will help you have a more satisfying career. If you already are a member, I would challenge you to become more involved in the Section's activities. Your unique set of skills and experiences are needed to help the YPS realize its full potential. In a previous issue of *Common Sense*, Tom Scaletta described AAEM as "the go-to organization on emergency physician professional satisfaction." Likewise, we want to develop the Young Physicians Section into the go-to section for the newer emergency physician.

MEMBERSHIP



Membership in the Young Physicians Section (YPS) is open to emergency medicine residency trained Associate or Full Voting members of the AAEM who are within the first seven years of practice after residency or under the age of 40. The YPS has been formed with the goal of promoting the advancement of its members' knowledge, careers and involvement in AAEM activities. To join or for more information, go to <http://www.ypsaaem.org> or email info@ypsaaem.org.

AAEM Young Physicians Section

The Young Physician in Academic Emergency Medicine: Tips for Success

by Jesse M. Pines, MD MBA

Vice President, AAEM Young Physician Section

Department of Emergency Medicine, Hospital of the University of Pennsylvania

Embarking on a career in academic emergency medicine can be very rewarding. Few careers outside the practice of academic medicine allow people to combine such diverse activities as teaching, research and clinical care. Emergency physicians trained as clinicians go into academic medicine for many reasons; some love to do research, some love teaching residents and working in a collaborative environment, but most enjoy both.

The transition from residency to academic practice can be difficult for clinically trained emergency physicians because many academic institutions require research and publication as criteria for academic promotion. However, the expectation that a clinician will be able to perform well-designed research without close mentoring and formal training is unrealistic given the methodological requirements for publishing in emergency medicine journals. Instead, graduating emergency physicians entering academic practice must specialize either clinically, in research or both in order to ensure a successful career in academic practice.

Based on my experiences as a recent emergency medicine residency graduate, I have created the following “Tips for Success.” I hope this article serves as a guide for gaining success early and ensuring a rewarding career for young emergency physicians.

1. Find a Niche: The general recommendation for emergency physicians entering academics is to do a fellowship, and I agree. Fellowships allow protected time to focus on developing skills and expertise in one specific area. Some residents are able to do this during their residency but most cannot. Also, given the increasing competitiveness for academic jobs in emergency medicine, a fellowship can give you a real “leg up” in landing that first job in the city where you want to live. Not having a specific niche or area of interest is, and has been, a common pitfall in academic emergency medicine. Because we work in such diverse areas, it is easy to get interested in being a generalist emergency medicine researcher. That is, today I’ll do a cardiac project, tomorrow one on dental pain and next week, one on EMS. I would not recommend pursuing a diversified research strategy. I did this during residency but have since focused on a few specific areas. What happens is that you end up scratching the surface in many different

areas, and it becomes very difficult to make a significant contribution in any specific area. You also need to do a new literature search every time you do another project, which can be very time consuming. You should choose up to two specific areas of focus where you want to make a contribution, understand the literature and then gain the skills needed. You can have a research niche, a clinical niche (such as hyperbaric medicine, education, toxicology or pediatrics) or both, but you should find a niche and find it early. That means you might have to say no to certain projects. If you’re doing research into acute coronary syndrome and a friend asks you to do a book chapter on snake envenomations, think hard before you agree. Some projects will take a lot more time than you expect. As you gain skills and expertise, more opportunities will become available to you; try and avoid as many distractions as possible that are not central to your niche.

2. Find a Mentor: Find a mentor who has both the time and interest to invest in you and your success. This is why fellowships can be so beneficial; it gives a reason for senior faculty (the mentor) to be interested in you (the fellow). The ideal mentor or fellowship director is a successful senior faculty member in your department (or in an outside department) with whom you can spend dedicated one-on-one time working to develop your ideas and maximize your success. This can be a challenge, however, because often senior faculty can be very busy. Also, if you are in a clinical fellowship and your mentor is not a strong researcher, find formally-trained and/or well-published researchers in your department who you can meet with to discuss your research projects in advance.
3. Be a Mentor: As you develop skills, it is important to give back and mentor others. This is the cycle of academic medicine. Make time to help others, whether they are other junior faculty, residents, medical students or others. Being a mentor is very rewarding, and from this experience, you may be able to reap dividends for a lifetime as your mentees gain prominence.

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AAEM Young Physicians Section

Tips for Success - continued from page 9

4. **Collaborate:** Since it may be difficult to frequently meet with a senior faculty mentor, find other people who are interested in your specific area and collaborate with them. Working in teams can be a frustrating process, but often team members have skills or perspectives that can improve the overall quality of your work. Early on, you should strive to put together a team who can work toward a specific goal; whether it is developing a clinical protocol or applying for a grant, there are huge benefits to collaboration.
5. **Seek Input before You Proceed:** Here's a tip in doing high-quality research: think about your projects carefully, write them down (including background, aims, hypotheses and skeleton tables-this can serve as the template for your paper) and then present your ideas to others in your department or those with formal research experience. I cannot stress enough the value of presenting your ideas. Getting input at the beginning can make your project better, refine your questions and increase the likelihood of final publication. First, think about the big picture regarding your project, "What is the question? Why is this important?" Charging forward with data collection first, then thinking about what it means later (yes, I have done this), is not a good way to do research. Good preparation and planning at the beginning of a project can really increase the chance that a project will succeed. Think about the result you want and what it means. I always like to think about the last line of the abstract and what it will say if my hypothesis is correct. If you don't think this is important or meaningful, you may want to rethink your project.
6. **Set Specific Goals:** Ask your mentor to sit down with you and map out specific goals regarding further training (i.e., research or clinical training) and put together a timeline. Short-term goals may include applying for a specific grant, writing a paper or performing a research project; long-term goals may include setting up a research program or a new clinical protocol in your area.
7. **Always Write It Down:** When you're committing to a specific set of goals or a project, write them down in your calendar so you can refer back to them. This will ensure that you're on track and moving forward appropriately. If you're developing a new idea, committing it to paper (or computer bytes) is absolutely essential. This will be the working document that you use either to get funding or departmental support for a new initiative. Also, by writing it down, you become more committed to the project.
8. **Keep At It and Don't Give Up:** Academic medicine is difficult, and there are often setbacks regarding specific projects and plans. Success takes perseverance and hard work. Don't get discouraged. Papers will get rejected, grants won't get funded, and you may suffer personal and professional setbacks. To be a real success in academic emergency medicine, you need to keep at it and stay focused on achieving your goals.

Ask the Experts: A New Common Sense Feature

by Joel M. Schofer, MD

Secretary-Treasurer, AAEM Young Physicians Section

Have you ever wanted to ask Joe Wood a question about your EM contract?

Did you ever wonder what Bob McNamara might think about the structure of your EM group?

In future editions of *Common Sense*, the Young Physician Section (YPS) will have an "Ask the Experts" section where AAEM members can ask questions, and YPS will find the expert best suited to provide an answer. If you have a burning question you'd like answered, e-mail your question to me at jschofer@gmail.com, and I'll make sure your question is answered in a future edition of *Common Sense*. Please note in your e-mail whether you would like your name to appear with the question or if you would prefer to remain anonymous.

In concluding, however, the federal court determined that the CMS information was not prejudicial or confusing, pursuant to Rule 403, and thus was admissible. And too, even though the citation and termination action ultimately were withdrawn, the court ruled that “the fact of the withdrawal has no effect on the admissibility of the [CMS] information.”

For a closer reading of the court decision, see <<http://op.bna.com/hl.nsf/r?Open=psts6sypjt>>.

EMTALA Prohibits Different Treatment of Patients with Same Symptoms

The U.S. District Court of the Eastern District of Missouri granted, on August 7, 2006, a motion for summary judgment in the case of Robert Irvin, Sr. and Nancy Irvin, the parents of decedent Delia White, who filed suit under EMTALA against Pike County Memorial Hospital (PCMH). In granting defendant’s motion, the court dismissed plaintiff’s claim that PCMH did not provide adequate medical screening of their daughter (Irvin v. Pike County Memorial Hospital, E.D. Mo., No. 2:05CV00014, 8/7/06).

The decedent arrived at PCMH’s ED at 10:20 p.m. on February 17, 2004, complaining of a headache with vomiting, which had begun three days prior. Decedent was not known to PCMH employee and ED director, Phillip Pitney, MD, who examined and discharged decedent within approximately two hours and after her headache had diminished. Pitney gave her standard migraine medications and instructed her to follow-up with her physician and to obtain a CT scan the next morning. The decedent died the next day of acute hydrocephalus. The plaintiffs held that there exist genuine issues of material fact as to whether PCMH provided appropriate medical screening to decedent. Defendant moved for summary judgment on all claims against it.

Pitney’s deposition included testimony that based on decedent’s complaints and history, which included a history of migraines; Pitney thought that decedent had “a recurrent common migraine headache.” He supported his opinion with data gathered from blood work, decedent’s vital signs and the results of a physical exam he performed. Since all the data were normal, and there was no change in

decedent’s past headache pattern, Pitney did not order other diagnostic tests and/or a neurological consultation or consultation with decedent’s physician.

The court reviewed the conditions for granting summary judgment, which include that the evidence must be viewed in the light most favorable to the non moving party and that there must be no dispute of material fact. In applying the test for defendant’s motion to this case, the federal court examined the operative language of EMTALA, which states that:

- A hospital such as PCMH “must provide for an appropriate medical screening exam within the capability of the hospital’s emergency department . . . to determine whether or not an emergency medical condition . . . exists”; and that
- The purpose of EMTALA was “to address a distinct and rather narrow problem - the ‘dumping’ of uninsured, underinsured or indigent patients by hospitals who did not want to treat them.”

The court ruled that EMTALA does not guarantee correct or non-negligent treatment in all circumstances. Rather, EMTALA only guarantees that there will not be any bias in treatment, to the extent that each patient is to be treated as other similarly situated patients are treated, within the hospital’s capabilities. Drawing on the precedent of previous courts’ EMTALA interpretations, this federal court wrote that “a plaintiff need not prove an improper motive on the part of the hospital to ‘dump’ the patient, but . . . that the ‘appropriate medical screening examination’ provision is only violated by disparate treatment of a patient . . . It is up to the hospital itself to determine what its screening procedures will be. Having done so, it must apply them alike to all patients.”

Finding evidence that Pitney treated the decedent the same as he would any other patient presenting in the same fashion, and that plaintiffs had not alleged or presented any evidence that decedent was treated differently from any other patient under similar circumstances, the court ordered that the motion of PCMH for summary judgment on plaintiffs’ complaint is granted.

You may examine the court’s decision at <<http://op.bna.com/hl.nsf/r?Open=psts6shnwy>>.

CHANGE OF E-MAIL ADDRESS

If you have changed your e-mail address or are planning to change it, please contact the AAEM office at (800) 884-2236 or info@aaem.org to update your information.

AAEM Position Statement Opposing the Creation or Recognition of an American Board of Disaster Medicine (ABDM) under the auspices of the American Board of Physician Specialists (ABPS)

The American Academy of Emergency Medicine (AAEM), a national professional society of board-certified emergency physicians, has serious concerns about the creation of the American Board of Disaster Medicine (ABDM) by the American Board of Physician Specialists (ABPS). We note that:

- A. The creation of any subspecialty board must follow a rigorous process as board certification is held out to the public as a marker of special expertise. For example, new subspecialty recognition by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) requires demonstration of a distinct body of knowledge and contributions to the scientific literature. There is extensive peer review of the application. The approval process typically takes many years to be completed. No information has been provided regarding the process used by ABPS to declare disaster medicine a recognizable subspecialty.
- B. Board certification requires a distinct program of preparation. No information has been provided by ABPS regarding the educational requirements and pathway to certification status. ABPS comments imply that previously acquired knowledge and experience is widespread enough to allow for the creation of the board and the administration of certifying examinations. This approach disregards the few disaster fellowship programs and EMS fellowship programs stressing disaster medicine that already exist and bypasses the traditional method for a physician to obtain specialist status.
- C. Creation of any new subspecialty board must be a transparent process and be done by experts in that particular field. No information has been provided

regarding the expertise or authority of ABPS to create such a board. If, in fact, disaster medicine is a domain of multiple clinical specialties, the various concerned professional societies need to be involved in the development and ultimate creation of any board addressing this field.

- D. A subspecialty board is primarily a certifying body and enforcer of established standards. We are concerned with the statement by a representative of ABPS indicating that the simple existence of a new board is "the integral step towards preparing America's Health Care system so that when disasters strike, we work together." Similarly, a subspecialty board should not be involved in "providing a knowledge base and advice to various organizations that engage in preparedness."
- E. A certifying examination must be scientifically created and formally validated as a tool which predicts expertise when passed. No information is provided regarding how or by whom the first certification exam is to be written or scientifically validated.

AAEM opposes the creation of the ABDM under the ABPS. AAEM further strongly cautions against its recognition by any local, state or federal authority as a unique certifying body for expertise in disaster or preparedness fields. Until such time as a formal, standardized and recognized process is completed to create a subspecialty and an appropriate and validated certification process, we oppose the informal and ad hoc efforts of ABPS to assert expertise and authority in this area.

Statement developed by AAEM Emergency Medical Services Committee. Approved by AAEM board of directors. August 14, 2006.

EM Unity Proposal Unanswered

In response to concerns among emergency physicians regarding division of the specialty's voice on critical issues, the AAEM board in May of 2005 passed a resolution offering unification of its state and federal efforts with the American College of Emergency Physicians. This included combined lobbying efforts and unification of the respective political action and the government affairs committees on a per member basis. We also offered a path to organizational unification at the state level.

The AAEM believes that synergy is possible and desirable on key issues such as tort reform, crowding and the on-call crisis. Cooperation in this manner would have created unity in the key external issues affecting EM

while allowing each organization to continue a separate focus on other matters affecting their members.

Unfortunately, after one and one half years there has been no response regarding this unity proposal to AAEM by the American College of Emergency Physicians. AAEM therefore assures its members that we will continue our current efforts and strive for greater influence at the state and federal level.

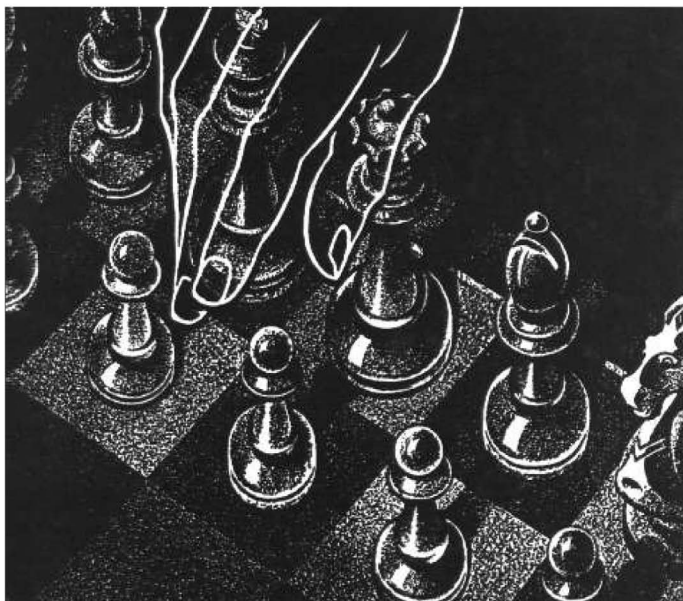
Addendum

Just before this issue went to the publisher, ACEP had relayed that they will deliberate at their January BOD meeting and has asked to present their decision to the AAEM Board in March.

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Threats to Board Certification: Why Your Residency Training in Emergency Medicine Should be Worth Something

by Brian Potts, MD MBA, AAEM/RSA President

As part of our core mission, AAEM/RSA strongly believes that the practice of emergency medicine is best conducted by a specialist in emergency medicine; a physician who has achieved, through personal dedication and sacrifice, certification by either ABEM or AOBEM. During my last four years on the AAEM/RSA board of directors, I have seen AAEM and AAEM/RSA stand up and fight against attempts to devalue emergency medicine board certification (yes, you are in residency for a reason). Another attempt by the American Association of Physician Specialists (AAPS) occurred at the North Carolina Medical Board in July. Luckily, through the hard work of AAEM and multiple other EM organizations, the North Carolina Medical Board (NCMB) denied the request from AAPS to have their credential, ABPS/BCEM, be recognized as equivalent to ABMS/ABEM and AOA/AOBEM. This prevented AAPS from allowing their credential to be accepted as evidence of emergency medicine expertise for purposes of licensure. Acceptance of BCCEM would have devalued our specialty residency training, our hard work and long hours, and threatened the entire specialty of emergency medicine.

To provide some background, AAPS is an organization that provides medical specialty certification. It consists of 14 different specialty academies, including one in emergency medicine, which consists of the overwhelming majority of its total members. Candidates without residency training in emergency medicine can obtain "Board Certification in Emergency Medicine (BCEM)" through different avenues. Any physician who has completed 1) an anesthesia or primary care residency program and 2) five years (7,000 hours) of clinical practice or two years consisting of a one-year emergency training program at the University of Tennessee followed by one year of clinical practice (or alternatively, two years of this program) is welcome to take the examination offered by the AAPS. AAPS board certification requirements allow physicians to totally bypass the process that turns medical students into properly trained and certified specialists in emergency medicine. This training program is not accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA). Prior to 2003, BCEM did not even require the completion of ANY residency training from physicians holding its emergency medicine certificates.

Since 1988, the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) have required a minimum three years of residency training in emergency medicine and passing written and oral board examinations to become certified by ABEM or AOBEM. ABEM is a member of the American Board of Medical Specialties (ABMS), which is formally recognized across the country as the authority in the specialty certification of physicians. ABMS was created by several of the official main-stream organizations in American medicine, such as the American Medical Association, The Federation of State Medical Boards and The American Association of Medical Colleges. The AOA is the authority for the specialty certification of Osteopaths.

After dealing with similar issues brought up by AAPS in multiple states last year, AAEM contacted every state medical board requesting to be informed whenever EM board certification activity appears on their agenda. Upon AAEM's notification of the situation in North Carolina just three weeks before the NCMB meeting, AAEM notified North Carolina ACEP and numerous national EM organizations. Howard Blumstein, AAEM Secretary-Treasurer and an emergency physician in North Carolina, testified at the NCMB meeting and was joined by NC-ACEP representatives. Opposition letters were also sent on behalf of SAEM, ACEP and influential EM leaders. We won this round against AAPS, and we should expect more challenges to board certification in the future.

Allowing BCEM physicians to claim board certification in emergency medicine as equal in standing to the one administered by the ABMS or AOA critically undermines the whole process of specialty training and the entire graduate medical education system. If you can learn unsupervised on the job, why have residencies in any medical or surgical specialty at all?

Through much dedication, we are training in emergency medicine residency programs to gain the latest academic knowledge and learn how to provide high quality emergency care while under the supervision of experts dedicated to guiding and counseling young emergency physicians. The Emergency Medicine Residency Review Committee (RRC) and the AOA impose, monitor and

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Resident & Student Association

The UCI-AAEM/RSA Emergency Medicine Symposium

by Dina Seif, Western Region Representative, AAEM/RSA Student Section

Repeating their ritual of the last three years in medical school, the boys from the group affectionately known as "The Back Row," took a study break they likely did not deserve. The three friends from the University of California, Irvine (UCI) School of Medicine, all budding emergency physicians, came up with a creative idea to organize and host the first Emergency Medicine (EM) Symposium for Students. In 2004, the UCI Emergency Medicine Interest Group (EMIG), with the help of the UCI Department of Emergency Medicine, hosted the hugely successful 1st Annual Emergency Medicine Student Workshop Symposium.

Students, residents and attending physicians from the surrounding allopathic and osteopathic medical schools were invited. More than 150 students were present for a morning of talks about "The History and Future of Emergency Medicine," by Dr. Antoine Kazzi, "Cardiac Emergencies," by Dr. Mark Langdorf and "F.A.S.T. Ultrasound," by Dr. Chris Fox. In the afternoon, students rotated through hands-on workshops including ultrasound, ACLS, trauma/code simulator, splinting and reduction, advanced airway, lumbar puncture and pediatric radiology.

By all accounts, the Symposium was a resounding success, and only two months later, students from UCI EMIG began planning for their 2005 event. The string of tragic global events that unfolded throughout that year inspired the coordinators to give this conference a theme – "Disaster Medicine in the 21st Century" – that would highlight the emergency physician's role in such situations.

"The world has awoken to a new reality where tragedies such as these are no longer theoretical scenarios, and we believe that it is of utmost importance that the medical profession begins the process of educating physicians, health care providers, and subsequently, the general public on the core concepts of pre-hospital and disaster medicine, including their roles as potential first responders," says Dr. Warren Wiechmann, founder of the EM Student Workshop Symposium, past President of the AAEM Medical Student Section Council, and now PGY-1 in emergency medicine at UCI.

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Threats to Board Certification . . . - continued from page 15

enforce very strict requirements on emergency medicine residency programs.

AAEM/RSA strongly believes that residency training is essential for all new emergency medicine physicians. AAEM/RSA will continue to take an active stand as an organization to stress the importance of EM residency training to obtain board certification in EM through ABEM or ABOEM. Patients deserve to receive high quality care from board certified emergency physicians when they seek care in an emergency department. Our emergency medicine residency training does and should mean something!

Note from the Editor, "We all need to recognize the large amount of time and energy that our AAEM staff puts in to keep up with the activities of every state licensure board. We could never maintain such a high level of vigilance without these dedicated individuals." David Kramer, MD FAAEM

AAEM/RSA Updates:

This should be another fabulous AAEM/RSA section of *Common Sense*. Included is an interview about the IOM Report conducted by AAEM/RSA Board member,

Jonathan Shultz, with Brent Asplin, a member of the IOM Committee. Daniel Nishijima has summarized a "Resident Journal Review" of key articles recently published that would be of interest to busy EM residents. He has coordinated another International EM article from Gabriel Lau about EM in New Zealand. Last, we conducted an interview of AAEM Past President, Antoine Kazzi, who is now working in Lebanon as the Chief of Service and Chair-Elect for the Department of Emergency Medicine at the American University of Beirut (AUB).

As a reminder, each resident member should consider serving as their residency program's representative to the AAEM/RSA Representative Council. Contact AAEM/RSA's Vice President, Elizabeth Hall at ehall@wellspan.org if you have an interest in contributing to AAEM/RSA and serving as a liaison to your program.

AAEM/RSA has a wonderful resident-track in the works for the AAEM Annual Scientific Assembly, March 12-14, 2007, in Las Vegas. Stay tuned and join us in Las Vegas for networking, education.....and some blackjack and poker.



Interview with Brent R. Asplin, MD: The IOM Report and the Future of Emergency Medicine

by Jonathan F. Shultz, MD MA

Brent Asplin, MD MPH FACEP, is the Department Head of Emergency Medicine at Regions Hospital in St. Paul, Minnesota, and is an Assistant Professor of Emergency Medicine at the University of Minnesota. Dr. Asplin served on the main committee for the Institute of Medicine's (IOM) reports on the Future of Emergency Care in the United States Health System, as well as on the subcommittee for Hospital-Based Emergency Care.

Jonathan Shultz, MD MA, is a second-year emergency medicine resident at Regions Hospital in St. Paul, Minnesota, and is currently serving on the board of directors for the AAEM Resident and Student Association (AAEM/RSA).

Jonathan Shultz (JS): The IOM report has been out for several months now. What kind of a response have you received, and what kind of action has occurred since the report was released?

Brent Asplin (BA): There has been very widespread media coverage, particularly early on, and people who would otherwise not be listening are now listening because of these reports. From an emergency medicine standpoint, it's critical that we take advantage of that opportunity. There's also a series of dissemination workshops that will be occurring this fall, and those will generate even more interest in the reports. The first one occurred September 7th in Salt Lake City. The second was October 27th in Chicago. The third one was November 2nd in New Orleans. And the final one is December 11th in Washington, D.C. The purpose of those dissemination workshops is to bring the public together in forums to discuss the reports, to talk about implementation barriers, and to discuss the committee's findings; what the committee got right and what was missing from the reports and to try and build more momentum toward actually turning the papers into action.

JS: What do you see as the most significant problems/issues in EM that will likely affect current EM residents as they enter the workforce in the next 1-3 years?

BA: This may be a transition point in emergency medicine. A lot of our struggles have been to create our identity as a specialty and to understand what the issues are within our specialty. I think that has been a key focus of our development over the past 30 years. If you look at the key issues highlighted by these reports, it really could be a tipping point within the development of emergency medicine. We established ourselves as

a specialty largely because we took on problems and issues that others didn't want to deal with. Because we were so successful in doing that, we were handed more and more problems. What the reports are highlighting is that the problems, challenges and issues we face can't be solved by the emergency department anymore. We can't continue to fill all the gaps. The biggest problem is the sheer volume of patients moving through the emergency department and the lack of places for them to go. You need to look at that from a system-wide perspective. It's not an emergency department problem, although we have to be a part of the solution. The problems we are facing in the emergency care system really highlight our failed approach to health policy.

JS: Do you foresee continued growth in EM residency programs?

BA: Yes, though probably not in every region. I think some regions or states have probably saturated their growth potential. And then there are other areas that are very under-represented and where we need more growth. There's a limit at some point. I think what policymakers do is going to have a huge effect on that; GME funding and what happens to it.

JS: The report cites the AAEM estimate that approximately half of all EDs are staffed by CMGs with majority ownership by non-physicians. Did the IOM discuss non-physician CMGs' influence in emergency medicine, and did they make any recommendations regarding the corporate practice of medicine by non-physician groups?

BA: There's not a specific recommendation about management structures within physician groups in emergency medicine. These are reports on the future of emergency care in the U.S. health system. They are not reports on the future of emergency medicine. Obviously, the two are closely linked, but the perspective of the committee was not 'How do we improve emergency medicine?' It was 'How do we improve emergency care?' I think this is a key example that if the IOM was doing a report on the future of emergency medicine as a specialty there's no doubt this would have been discussed in more detail, and there would have been more recommendations on this.

JS: Has there been any action/activity at the federal level in response to the IOM report?

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Resident & Student Association

UCI-AAEM/RSA . . . - continued from page 16

Through a series of didactic sessions and hands-on skills workshops, students learned about field triage and assessment, biological and chemical exposures, sarin gas case study, disaster response in natural disasters, management of blast and crush injuries, spinal immobilization and patient transport and hazardous materials decontamination. The keynote speaker was Dr. Paul Pepe, Professor of Medicine, Surgery, Public Health and Chairman of Emergency Medicine, University of Texas Southwestern Medical Center and the Parkland Health & Hospital System.

The Orange County Fire Authority performed a simulation of a multiple vehicle trauma with a hazardous chemical spill. While HazMat crews donned protective gear and surveyed the scene, the fire chief narrated the dramatic events. Buzz saws were used to gain access to trapped victims. Once extricated from their cars, the injured patients were taken to a decontamination area to remove a powdery chemical from their bodies so paramedics and EMTs could attend to their injuries. This simulation was a highlight for many of the students attending the Symposium.

Almost three years since the Emergency Medicine Student Symposium concept was born, the three UCI medical students have moved on to the next phase of their career – emergency medicine residency. And they have left behind huge shoes to fill. With endorsement from AAEM/RSA and collaboration with Southern California medical

schools, our goal is to create the first national emergency medicine conference for medical students.

The UCI-AAEM/RSA Emergency Medicine Symposium will take place February 10, 2007, in Orange, California. This year, the planning committee has lofty goals – we hope to attract more than 250 students from across the U.S. Major objectives for the 2007 Symposium will be to bring EM student groups together for the first time to increase networking and share experiences. Program directors and residents will host a candid panel discussion about career choices, residency and the application process. Lectures from expert faculty will introduce students to important and emerging topics in EM. The workshops will be as interesting and challenging as ever. A networking lunch will provide a unique opportunity for close student and faculty interaction, and the Research Forum will give students a chance to present and defend their research during moderated poster sessions.

The 2005 Symposium received outstanding reviews by student and physician participants, and 2007 promises to be even better. This will be a rare opportunity for student and faculty interaction where students can learn about emergency care in a stimulating, interactive and hands-on environment. I encourage all student members of AAEM/RSA to attend this unique event.

For more information, please visit <http://www.socalsymposium.com> or email dseif@uci.edu.



- Disaster simulation with the Orange County Fire Authority at the UCI-AAEM/RSA EM Symposium



Interview with Brent R. Asplin, MD . . . - continued from page 17

BA: The next 12-24 months are going to be really critical. It's too early to expect that Congress would have acted. But, if we haven't seen any response a year from now, then that's when you start to remind people. I think the recommendations from the dissemination workshops are going to highlight these issues again next spring when we have a new Congress. And I think that's going to be good timing. So, 2007 will be a key year.

JS: Given the shortage of critical care specialists nationwide, do you believe that there will be a change in the existing rules that prevent EM-trained physicians who have completed a critical care fellowship from sitting for the subspecialty exam in critical care?

BA: I sure hope so. The current political structure of critical care fellowship and board certification for critical care is opposed to having EM graduates be certified. This is a political struggle, and the statement that the committee made is unequivocal. It didn't say that emergency medicine graduates should be certified, but it said that anyone in an acute care specialty who completes an accredited critical care fellowship should be eligible for board certification. So, it's pretty clear. I think that will help, and I hope that those who are in charge of making decisions about who's eligible for board certification will recognize that if the Institute of Medicine is calling for this, it goes beyond simple specialty-driven politics. Hopefully, there will be enough people that rise above those political conflicts to recognize that this is a need for our healthcare system and that emergency physicians who complete a critical care fellowship can help fill that need.

JS: The IOM report outlines a number of persistent and developing problems within the field of emergency medicine. Did the IOM consider how these issues affect the training and education of emergency medicine residents?

BA: How those problems specifically affect emergency medicine training, that's one area that we didn't spend a lot of time on. However, I think you're being trained in the best healthcare policy laboratory in the health system. I don't think there is a better health-policy lab than your local ER. We are fortunate to be getting the best medical students into our specialty. Given the type of people who are coming into our specialty, there's no reason why emergency physicians can't help lead healthcare. Maybe these reports will mark the change when emergency medicine shifted from an internal identity-based focus to uniting and really started moving broader issues in healthcare, because we can have an influence on healthcare.

JS: The report notes that although 21 percent of the population lives in rural areas, less than 12 percent of

EM physicians practice in rural areas and yet ACGME requirements make it almost impossible for a rural residency program or hospital to develop a "rural" emergency medicine residency program. Do you foresee changes in the ACGME requirements that would allow development of rural EM residency programs?

BA: Yes, I do think that the ACGME requirements are going to change to allow for some more rural-based programs. I think that one change has already happened, and that is the approval of the joint EM/FP residency program. What are these joint programs going to look like? I think dual training in primary care and emergency medicine is a golden opportunity for people who want to go into a rural area, be the medical director of an emergency department and vastly improve the quality of care that's delivered in that department by working with their primary care colleagues and have a family practice component on the side of that. However, there is a fundamental density requirement that you have to have in order to be competent as an emergency physician as far as patient encounters, procedures, spectrum of illness and acuity. You have to have a concentrated experience in a location that has a high enough patient volume to support that experience. I think the rural EM programs are going to have to be collaborative, and they are probably still going to have to be paired with a concentrated experience in a high-volume environment.

JS: What can EM residents do to make sure that the IOM report gains momentum in the national spotlight and that the committee's recommendations are put into action?

BA: First, you have to read the reports. This should be required reading, even if all you have time to do is read the executive summaries and pick out a couple of chapters and read them. You definitely need to be familiar with the reports, with what the recommendations are, and you should be discussing them in your residency program. I think that is good for your development. If you're not aware of the recommendations, it's going to be very difficult to help put them into action. The second thing is that you need to focus. That may be as simple as picking a group that has a relationship with a hospital that can really make some headway with these recommendations. Pick something that you care about that is an issue in your hospital. Also, participate through your EM organizations, whether it's AAEM or ACEP. Whatever AAEM and ACEP's differences have been, this is an opportunity to have a unified voice as a specialty. The more unified we are, the more likely we are for this next phase in our specialty to be successful.

The views and opinions stated in the above interview do not reflect or represent the policy or position of the American Academy of Emergency Medicine.



Resident Journal Review

This is a new column providing journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles nor is it wholly comprehensive of all the literature published. Rather it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition will include articles published over a two month period. These selections are from papers published in August and September 2006.

- Daniel Nishijima, MD, Christopher Doty, MD, and Amal Mattu, MD

1. Moran GJ, Krishnadasan A, Gorwitz RJ, et al. Methicillin-Resistant *S. aureus* infections among Patients in the Emergency Department. *N Engl J Med* 2006; 355(7):666-674.

This article looked at skin and soft-tissue infection of ED patients (n = 422) in 11 cities and found that the prevalence of community acquired MRSA was 59% overall (ranged from 15-74% in various cities). MRSA susceptibilities were: trimethoprim-sulfamethoxazole (100%), rifampin (100%), clindamycin (95%), tetracycline (92%) and fluoroquinolones (60%). An anti-staphylococcal penicillin or cephalosporin was the most common antibiotic given, of which MRSA isolates were not susceptible. However,

there was no association between patient outcome and susceptibility of pathogen to prescribed antibiotic, suggestive that MRSA infections can be cured with adequate drainage alone. Risk factors for MRSA infection included: history of MRSA infection (OR 3.4), close contact with similar infection (OR 3.8) and reported spider bite (OR 3.0).

2. Melniker LA, Leibner E, McKenney MG, et al. Randomized Controlled Clinical Trial of Point-of-Care, Limited Ultrasonography for Trauma in the Emergency Department: The First Sonography Outcomes Assessment Program Trial. *Ann Emerg Med* 2006; Vol 48(3):227-235.

This was a randomized controlled clinical study at two Level I Trauma Centers looking at 262 patients with suspected torso trauma randomized to either FAST (Focused Assessment with Sonography for Trauma) or usual care (control). Primary outcome measured was time to operative intervention. Time to operative care was 64% (48 vs. 76 minutes) less in the FAST group compared to control patients. Moreover, patients in the FAST group had few CTs, shorter hospital stays and less complications compared to the control group.

3. Safdar B, Degutis LC, Landry K, et al. Intravenous Morphine Plus Ketorolac Is Superior to Either Drug Alone for Treatment of Acute Renal Colic. *Ann Emerg Med* 2006; Vol. 48(2):173-181.

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Emergency Medicine in New Zealand

This is a continuing column that examines the practice of emergency medicine in various countries around the world. This issue will look at EM in New Zealand. This article is written by Gabriel T. Lau, MD FACEM FACEP, an American board-certified emergency physician who is currently working in the Department of Emergency Medicine at Wellington Hospital in Wellington, New Zealand.

Background

New Zealand is located in the South Pacific Ocean, a three hour flight from Australia, the nearest continent, and an 11-hour flight from Los Angeles, where most direct flights from the United States originate. New Zealand is comprised of two main islands, referred to as the North and South Islands, as well as numerous smaller islands (the Chatham Islands being the largest). Most of the population resides on the North Island, which includes the major cities of Auckland and Wellington, the nation's capital. Christchurch and Dunedin are smaller cities located on the South Island. The geography consists of long coastal areas with numerous beaches, mountain ranges, some of which host winter skiing, and large areas of rolling terrain, most of which has been converted into

farmland. The varied geography has resulted in numerous New Zealand locations being prominently showcased in several large films (Lord of the Rings, River Queen).

New Zealand is one of the more recently settled countries, with the first Polynesian settlers arriving sometime between the 13th and 15th centuries and numerous European settlers arriving in the 19th century. Today, the population is comprised of 4.1 million people, with around 70% being of European origin and around 15% of indigenous Maori descent. Although the two official languages are English and Maori, almost everything is communicated in English.

The government is a parliamentary democracy (with a prime minister), as well as a constitutional monarchy (recognizing Queen Elizabeth II as the Queen of New Zealand). There is very little unemployment in the country (3.4%), and there is an ongoing commitment by the government to encourage skilled immigration.

Healthcare

The New Zealand health system is publicly funded. Although there are private hospitals, they do not have

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emergency departments exist primarily as an avenue for getting non-urgent specialty procedures (such as CABG, hip replacements and cholecystectomies) done in a more expedited manner. Most people do not have private insurance and go onto a waiting list at the public hospitals to get their specialist appointments arranged or their surgical procedures done.

Practicing emergency medicine in New Zealand has similarities to working in an American HMO: general practitioners (GPs) serve as the gatekeepers and manage most patients, there is a formulary of subsidized medications one must pay attention to and non-urgent procedures and investigations are often performed based on prioritization. Residents and citizens receive free emergency care, but most must pay a fee to see their GP and to get prescriptions filled at the pharmacy. As a result, part of the daily volume seen in the emergency department consists of people who cannot get an appointment with or afford to see their GP, although the number of "non-emergency" visits is smaller than one would expect. Since the public is not billed for ED treatment, patient registration is much simpler, and documentation only needs to be sufficient for medico-legal purposes, not for coding or revenue capture.

One feature unique to New Zealand is the lack of personal injury lawsuits. Patients who suffer injury, through accident or "medical mishap," are covered by the no-fault government sponsored insurance carrier, Accident Compensation Corporation. New Zealand has always been on the cutting edge of providing health coverage, and ACC was formed in 1974 to provide coverage to people who have had injuries. As a result, there is no "malpractice" in the conventional sense, and medical protection insurance is required only to help defend a Coroner or Health and Disability Commissioner Inquiry. The relatively calm medico-legal environment results in correspondingly low malpractice insurance rates: the 2006 premium for coverage was \$1200 and is almost always paid for by the employer.

History of Emergency Medicine

The development of emergency medicine in New Zealand closely parallels the development of the specialty in Australia and shares many similarities to the evolution of the specialty in the United States and Canada. Although emergency medicine was first recognized as a distinct specialty in New Zealand in 1995, emergency departments have been present throughout the country for many decades. Reflecting the British influence on medicine in the Australasian community, emergency departments were once referred to as "Accident and Emergency Departments," staffed

by "casualty officers." Even today, many people still refer to the emergency department simply as the "A and E," although the use of the term "casualty officer" has gone by the wayside.

Pre-hospital Care

Pre-hospital care is activated by dialing the universal emergency number, '111,' and staffed by ambulance personnel with either ALS or BLS skills. In many areas, ambulance paramedics with advanced skills may be dispatched based on the severity of the initial call. Unlike other countries, there is only an occasional need for a doctor to respond as part of the ambulance crew. Interfacility transfers, especially those done by air, generally involve a paramedic with either an intensive care registrar and/or a transfer nurse.

Medical Training and Specialization

Training in the field of medicine and subsequent specialization, is modeled after the British system. Medical school is six years in length, with no requirement for an undergraduate degree prior to admission – many students enroll immediately after completing high school studies, while some are selected for medical school based on an intermediate year at university, and others may already have completed a different degree. As a result, it is possible to complete medical school by age 23-24. The degree received in New Zealand is a Bachelor of Medicine and Bachelor of Surgery (MB ChB), roughly considered the equivalent of an American MD degree. Requirements for specialty certification (often referred to as a fellowship) in New Zealand are dictated by the respective specialty college or society. The government generally uses one's fellowship as the basis for granting "vocational registration," which can be considered the license for one to practice as a specialist in a particular field. In Australia and New Zealand, the Australasian College for Emergency Medicine (www.acem.org.au) specifies the training requirements in emergency medicine, accredits training sites and administers fellowship examinations.

Specialization generally is a much longer process compared to the United States. It takes a minimum of seven years postgraduate training in order to become a fellow in emergency medicine. Training is comprised of two years basic training (generally the first two years out of medical school), one year of provisional training (work in an emergency department and other approved settings), completion of primary examinations, an additional four years of advanced training (combination of work in emergency department and other approved settings), publication or presentation of a research project, and finally completion of a fellowship examination. The primary examinations are in the areas of anatomy, pharmacology,

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Resident Journal Review - continued from page 20

This randomized controlled study looked at 130 patients with the diagnosis of renal colic with at least moderate pain randomized to three groups: morphine iv alone (5 mg at time 0 and 20), ketorolac iv alone (15 mg at time 0 and 20), and a combination of morphine iv (5 mg at time 0 and 20) and ketorolac iv (15 mg at time 0 and 20). The mean difference in change in pain score (visual analog scale at time 0 and 40 minutes) between the combination group and morphine group was 1.8 cm (95% confidence interval [CI] -3.3 to -0.1) and, compared to the ketorolac group, was 2.2 cm (95% CI -3.7 to -0.5); $P < .003$. Patients in the combination group also required less rescue morphine and did not have a significant difference in side effects compared to either group.

4. Hazel A Everitt, Paul S Little, Peter W F Smith A randomized controlled trial of management strategies for acute infective conjunctivitis in general practice *BMJ* 2006; 333:321.

This article looked at 307 patients with acute infective conjunctivitis randomized to three strategies – immediate antibiotics with chloramphenicol eye drops, delayed antibiotics (antibiotic prescription given but filled at the discretion of the patient or the parents) or no antibiotics. Main outcome measures were severity of symptoms on days 1-3, duration of symptoms and belief in the effectiveness of antibiotics for eye infections. Duration of symptoms was found to be less with antibiotics: no antibiotics (controls) 4.8 days, immediate antibiotics 3.3 days (risk ratio 0.7, 95% confidence interval 0.6 to 0.8), and delayed antibiotics 3.9 days (0.8, 0.7 to 0.9). However, there was no difference in severity of symptoms on days

1-3 between groups. The use of antibiotics was 99% in the immediate treatment group, 53% in the delayed group and 30% in the control group. Authors recommend the delayed strategy for acute infective conjunctivitis, because it reduces antibiotic use while providing similar duration and severity of symptoms to immediate antibiotic treatment.

5. Garcia MJ, Lessick J, Hoffmann, MH for the CATSCAN Study Investigators. Accuracy of 16-Row Multidetector Computed Tomography for the Assessment of Coronary Artery Stenosis. *JAMA* 2006; 296:403-411.

This multi-center study is the largest study looking at the utility of 16-Row Multidetector CT for the assessment of coronary artery stenosis using coronary angiography as the gold standard. In evaluating 1629 coronary segments, only 71% were deemed evaluable by MDCT, of which the sensitivity for detecting $>50\%$ stenosis was 89%, while the specificity was 65%. Because of the high percentage of non-evaluable coronary segments and the high false positive rate, MDCT is not quite ready for routine clinical practice.

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when minutes count



Interview from Lebanon: Dr. A. Antoine Kazzi

by Daniel Nishijima, MD and Brian Potts, MD MBA

The recent war between Hezbollah and Israel ravaged Lebanon from July 12, 2006, until a United Nations brokered ceasefire went into effect on August 14, 2006. The conflict cost the lives of nearly 1,200 people in Lebanon and wounded another 3,500, most of whom were civilians, as well as approximately 160 Israelis. Of the Lebanese civilian casualties, almost one third involved children under 13 years of age. The United Nations Development Program (UNDP) initially estimated about 35,000 homes and businesses in Lebanon were destroyed in the conflict, while a quarter of the country's road bridges or overpasses were damaged. It has been estimated that the overall economic losses for Lebanon from the month-long conflict between Israel and Hezbollah totaled approximately \$15 billion.

This is an interview with Dr. Kazzi conducted on August 21, 2006, about the current situation in Lebanon and about the month long conflict between Hezbollah and Israel.

Dr. A. Antoine Kazzi is the Chief of Service and the Chair-Elect for the Department of Emergency Medicine at the American University of Beirut (AUB). AUB is widely regarded as one of the lead teaching tertiary medical centers in the Middle East. He is also an Associate Professor of Clinical Emergency Medicine at the Department of Emergency Medicine at University of California, Irvine, as well as the Immediate Past President of the American Academy of Emergency Medicine.

1) Could you describe your role within AUB and also the role of EM at the hospital?

I am currently serving as the Chief of Service and the Chair-Elect for the Department of Emergency Medicine that is being established at the American University of Beirut.

The emergency department at AUB has a similar role to the role emergency departments play in U.S. hospitals. Mainly, ABMS board certified physicians work here at AUB to train residents, most of whom are residents (PGY-II) and interns with occasional PGY-IV coverage in the internal medicine section. Considered the gate to the institution, 40% of inpatient admissions come through the ED.

With regard to EM, AUB has unfortunately lagged up to 35 years behind the rest of the U.S. medical schools and academic centers. For decades, emergency medical services have been provided through a fragmented multidisciplinary Emergency Unit (EU).

At AUB, EM has been functioning as a fragmented multidisciplinary under-administered operation for many decades. What should be a department – the ER – is referred to as an "Emergency Unit (EU)." The reality is that its fragmentation has made it often operate sub-optimally and certainly not as consistently as a "Unit" should have. Services and disciplines staff different overlapping sections of the EU and run into significant, almost daily, conflict over who should assume or continue the care of specific patients.

However, the exceptional service provided by the EU and AUBMC to Beirut and Lebanon should be acknowledged. The EU serves as the entry point for all acutely ill or injured patients at one of the preferred Lebanese tertiary care centers. It is a vital community resource which is well known to the Red Cross, Civil Defense and patients as the only emergency service that will NEVER turn away ANY patient presenting to its door until they have been assessed and properly treated or stabilized. No patient is refused proper assessment. Its policy and intent have always been to evaluate all patients who reach its doors and to properly stabilize them.

AUBMC is widely considered to be the prime trauma center in Lebanon and often serves as a default burn center. This vital role for AUB certainly depends on the emergency unit, its operation, resources and administration. The exceptional importance of the AUB emergency services has been repeatedly demonstrated through its dealings with the unfortunate mass casualty events in Beirut. The AUBMC Emergency Unit is the preferred destination for the Lebanese Red Cross and Civil Defense whenever they are faced with mass casualty events such as the explosion which murdered Prime Minister Hariri (126 casualties in 2 hours), the February 5th Ashrafieh riots (47 casualties in 3 hours) and the July 2006 war (155 war traumatic casualties, 63 inter-hospital transfers and more than 1,300 displaced patients).

On the clinical side, the AUB Medical Center Emergency Unit currently treats the largest number of patients in Beirut and likely in all of Lebanon: 41,000 registered patients in 2005. It is also estimated that another 10% (4000 patients) are evaluated and assessed but leave prior to the completion of ED registration. The acuity has always been high and also remained unchanged, with nearly 1/5th of EU patients requiring admission to the inpatient setting at AUBMC. This represents 40% of all AUBMC admissions.

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pathology and physiology – are very basic science focused and very challenging, reminiscent of the U.S. medical boards – part I. Additionally, both the primary and fellowship examinations involve a multiple-choice and essay written components, as well as an oral component.

Emergency Department Operations

The hierarchy of emergency medicine also reflects the British influence of having a house officer based workforce. The various titles given to house officers reflect their skills and experience since medical school graduation: PGY-I and –II doctors are considered “house surgeons” and are the most junior doctor in the workforce. Senior house officers (SHOs) are post PGY-III doctors, not necessarily in a training program, many who are rotating through the emergency department to gain more experience. Registrars are often specialty trainees, generally PGY-IV and beyond, who are skilled and experienced in managing most ED cases. Those who have completed their specialty certification and have become fellows are referred to as either “consultants” or “specialists” and are considered senior doctors.

Often, there is only one consultant supervising a combination of registrars, SHOs, and house surgeons staffing the emergency department. The role of consultant includes direct supervision of house officers, regular teaching responsibilities, other administrative duties and seeing patients. Some smaller hospitals may have only one or two ED consultants on staff, resulting in the consultant doing more administration and less patient care. There are very few, if any, emergency departments with a consultant on site after 10 p.m. Night coverage is generally provided by a registrar supervising other house officers, with a consultant available by phone (at home) for any questions or complicated cases.

As with emergency department volume in the United States, annual attendances in New Zealand are gradually increasing, a reflection of an older population and a decrease in available non-emergency department after hours care. Greater efficiencies in ED care, the result of having more specialists available, have reduced waiting room times and have also been responsible for increasing attendances. ED overcrowding also occurs in New Zealand and shares some similarities to problems in the United States. The biggest factor causing overcrowding is the inefficient use, and subsequent lack of, inpatient hospital beds. Another important variable in ED overcrowding in New Zealand is the cautious decision-making and slow admissions processes inherent in any hospital staffed by training doctors.

Most emergency departments have either recently gone through, or are going through, major facilities redevelopment. Technology is similar to most other first world countries: multi-detector CT scans are the norm, most ED specialists incorporate ultrasound into their daily practice, and the latest in critical care intervention devices are present in the resuscitation area of most EDs. Some problems are more

aggressively managed as inpatients (for example, abscesses are generally taken to the operating theatre), while other problems are aggressively treated in the emergency department and often discharged (new onset atrial fibrillation). The lack of a formal “trauma service” in New Zealand means that most trauma resuscitations are managed by the emergency department specialists.

Emergency Medicine Working Conditions

The average working week for emergency medicine specialists, including the odd (1:4) weekend, comes out to just over 40 hours. Many EM specialists work 8A-5P, and cover evenings once or twice a week. Currently, there are no obligations for EM specialists to be present overnight, although this may change in several years. The average salary for senior doctors, regardless of specialty, is around NZ\$140,000, although other bonuses may bump this up 20-40%. There is also an annual salary increment based on years of experience. With the fluctuating New Zealand dollar (currently NZ\$1 = US\$0.63) the pay is less than in the United States and other countries, but the position comes with excellent benefits. There is a collective agreement in place for all specialists, such that all clinicians receive six weeks annual leave, ten days conference/education leave, NZ\$8500 CME funds and around ten paid holidays. Combined with a favorable medical legal environment, numerous opportunities for teaching and few weekends/no nights for senior clinicians in the foreseeable future, New Zealand has become very attractive to physicians working in the United States and other countries.

The Future of Emergency Medicine

There is currently a shortage of emergency medicine specialists in New Zealand, especially in rural areas, as more hospitals realize the benefits of having ED specialists on staff. This shortage is not expected to improve significantly in the next few years, as other areas of the world (US/UK) are also experiencing physician shortages and attracting New Zealand-trained clinicians. As a result, there are generally positions available in rural and suburban areas, and overseas doctors are regularly recruited to move to New Zealand to practice. Additionally, the government is actively encouraging physicians to immigrate to New Zealand by emphasizing the natural beauty of New Zealand, the numerous outdoor recreational opportunities and providing a streamlined process to permanent residency. The working atmosphere in New Zealand is less hectic and more relaxed than in other countries; coupled with the large amount of annual and holiday leave, New Zealand has become a very popular place for emergency physicians to move to and settle down.



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Unlike the outpatient clinics, the EU provides acute care to a wide variety of emergency needs for the community and medical center, for patients who arrive in acute distress with a large number of extremely anxious and demanding family members and visitors. The space allocated for these visitors is very inadequate and underutilized. The EU clinical area is then overcrowded by family members and visitors who have no place to sit and spend their time interfering again and again with the physician and nursing care of other patients.

The expectations and the clinical, operational and administrative needs of patients and families in the EU are exceptionally high, certainly exceeding those seen anywhere in the USA. Yet, everyone wants everything done for free or very inexpensively; most expect every resource or AUB contact they have to be promptly available to attend to their needs, yet without flaws or delays.

2) What is the role of EM in Lebanon?

In Lebanon, EM remains in a development phase. Full-time staffing by European-trained career emergency physicians can be found in a handful of hospitals out of 160 in this nation of five million inhabitants. There is still no formal national residency program and no national peer-reviewed journal. However, a professional EM society representation has been established for more than four years, and it has begun organizing or sponsoring national EM conferences and workshops. The Specialty Certification has been recognized by the Ministry of Health, the Lebanese Order of Physicians and the National Social Security Fund (NSSF). They ALL have recognized the specialty, its EM specialists and their right to earn professional fees as specialists for the emergency care they provide to patients in Lebanese EDs. However, the medical staff and the administration of hospitals all over Lebanon have not yet recognized us as a necessity for every emergency patient encounter. Yet even when they do, they frankly restrict our ability or right to earn professional fees for the work we do when caring for their emergency patients.

Hospital-based and national efforts have begun trying to address the numerous problems in the EM delivery chain, to establish proper standards and to integrate systems linking the pre-hospital, ED and in-hospital phases of the chain.

3) Can you estimate or describe the increased burden on the ED and how the ED has adapted to this?

The ED, its nurses, staff and residents all have experienced a daily overload in the ER with a near-doubling of the daily patient load. All providers are working increased hours. The AUB decided to support the community and all those presenting to its doors during such tragic times.

We have instituted a "Doors Open Policy" for all people to receive care for free in the emergency department. Normally the ED and Lebanese hospitals are a "pay-as-you-go" system for 80% of patients.

There are many displaced patients from the south of Lebanon seeking care because so many medical centers have been closing their doors and ERs. At least four hospitals are closed in the southern suburbs of Beirut. These were the most important ones in delivering the bulk of emergency and comprehensive care to the one million or more patients living in the southern suburbs. Another ten hospitals in Beirut (including one of the larger ones) have stopped accepting or have restricted admissions even through their emergency departments/rooms. They are limiting themselves to receiving casualties of war, partly due to their closer proximity to the bombed areas and their bed and nursing capacity/casualty load.

At AUB, the ED has cared for nearly 160 traumatic casualties directly injured by the war. I believe this is the highest number seen by a single ED in Beirut (where we have 30 medical centers). The death to casualty ratio is high (meaning relatively more death than wounded, because the bombs are leveling ten-story buildings, causing crush injuries and near-impossible extrication issues...similar to what was seen in NY during the 9/11 tragedy).

Boluses of five-six traumas at a time occurred during this conflict. However, this was far less than the 50-100 trauma patients that we would see in two-four hours during the February 2005 explosion in Beirut and the February 2006 riots.

Overall, we saw fewer shrapnel injuries than in previous wars. There were more crush injuries from collapsed buildings. We are getting transfers from throughout the country on a daily basis, some without any warning, who arrive in the ED for stabilization and care.

4) I know you are practically working around the clock at the hospital. Is the rest of the hospital staff working around the clock as well? How has your life been disrupted by the conflict?

Yes, there has been many more hours for everyone, with everyone working 14-24 hour days during this period. Everyone's life in Lebanon has been put on hold. Many of us often slept at work – especially at the start of the conflict. Nurses and docs are all awoken to support each other during issues that arise frequently during a 24 hour period. I usually work 17 hour days, balancing time in the clinical area and my administrative duties.

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Interview from Lebanon . . . - continued from page 25

5) What has been your most rewarding experience(s) since the beginning of the conflict? What has been the most frustrating experience(s) since the beginning of the conflict?

The most rewarding experience has been doing "what we do best" - the resuscitation of shock, trauma and burn patients. I am proud of the fact that no one gets turned away and that we truly give care to all patients who present to our doors. It is also nice to see community members coming in to volunteer and help distribute food, etc.

The most frustrating experience has been not being able to do more. We have limited space and resources and we often feel that our ED has no other institution or party interested or available to support us or the patients we end up with. During this war, we took care of many injured people. Among them, children with massive burns or crush injuries and the 85-90 year-old elderly such as two women who ended up one with strokes from dehydration and severe hyponatremia from being under rubble in a demolished village or from running from bombs through three villages.

6) We all saw the lack of government coordination with Hurricane Katrina last year in the U.S. How has the government in Lebanon (or other organized entities) responded to this crisis?

The government could have done more. There has been no proper coordination between hospitals, and there are some absurd decisions, policies and lack of policies when they are critically needed. Local hospitals have been doing an amazing job with the injured and displaced, especially those in the south of Lebanon. The Lebanese Red Cross was truly amazing. Its volunteers were targeted and some died while in service. They and the Civil Defense were true heroes!

7) In terms of damages, to the infrastructure, to the national psyche, to the economy, to the emotional strain, how does this conflict compare to the civil war years?

The infrastructure and economy for much of Lebanon has been destroyed. There has been a 50% rise in ED patient visits; they came on a daily basis for five weeks and not intermittent bursts like past conflicts.

8) Has there been any foreign aid in terms of money, doctors/nurses/EMS volunteering time, etc., to flow into Beirut? Are the hospital resources holding up?

We are worried about supplies. But so far they have everything that they need for the most part. The hospital has been running very low on fuel to keep generators going so the A/C has been turned off to conserve. The

community clinics are getting supplies from outside sources. Volunteers are used mostly in outreach settings and in shelters and not in the ED since we only want trained people there.

9) Has there been any mobilization to send teams down to the southern areas of Lebanon?

In very few instances. A few groups traveled down to the south, but we are already functioning at 80% above capacity with our current patients and the transfers from the south for higher level of care.

10) I'm sure there are emergency physicians who would like to volunteer aid to Lebanon. How would you recommend going about doing so?

I would not recommend volunteering to us directly because credentialing and logistics would be time consuming and very difficult. We would want someone to make a six month commitment to make it worthwhile.

There are many other ways in which EPs can help. The Red Cross, Red Crescent and Civil Defense have done, and continue to do an incredible job! Support them please... Donations can be made to the "EMS (Emergency Medical Services)," in the name of: Mrs. Rosy Boulos - President of Lebanese Red Cross-First aid Team Section. Follow website: <http://www.dm.net.lb/redcross/>

Also, AUB has recently established and is seeking funds for the AUB Medical Emergency Fund to help pay for the care that we are currently providing—and expect to be providing for some time. Faculty and staff members from several AUB faculties are involved in the University's efforts to provide a comprehensive approach to care that includes evaluation of environmental and individual status, education, support, screening, prevention and—when required—early diagnosis and treatment. Please consider helping us with that.

If you want to make a financial donation to support these efforts, you can do so online by going to the following link: www.aub.edu.lb/challenge/give.html where you can make a donation. Times such as this one certainly remind us that AUB is, as stated in its mission statement, an institution founded "to serve the peoples of the Middle East and beyond."

"UN likely to cut request for Lebanon emergency aid", Reuters, 2006-07-23.

^ War wiped out 15 years of Lebanese recovery - UNDP. The Daily Star (24 August 2006). Retrieved on 2006-08-24.

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To respond to a particular ad: AAEM members should send their CV directly to the position's contact information contained in the ad. If there is no direct submission information, then you may submit your CV to the AAEM office noting the response code listed at the end of the position description in a cover letter. AAEM will then forward your CV to the appropriate professional.

To register yourself in the Job Bank: AAEM members should complete and return a Job Bank Registration Form with a current copy of their CV, which will allow them to stay current on all available positions within the bank. There is no charge for this service. Contact the AAEM office for a registration form.

To place an ad in the Job Bank: Equitable positions consistent with the Mission Statement of the American Academy of Emergency Medicine and absent of restrictive covenants, will be published for a one time fee of \$300, to run for a term of 12 months or until canceled. A completed copy of the Job Bank registration form, a signed copy of the Certificate of Excellence and payment must be submitted in order to place an ad in the Job Bank.

Direct all inquiries to: AAEM Job Bank, 555 East Wells Street, Milwaukee, WI 53202, Tel: (414) 276-7390 or (800) 884-2236, Fax: (414) 276-3349, Please contact Shauna Barnes to learn more about the AAEM Job Bank at sbarnes@aaem.org

The following groups (identified with an) have submitted the AAEM Certificate of Excellence, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:*

*ALABAMA

Mobile, Al. Seeking full-time BE/BC emergency physician to join democratic 7 person group staffing community hospital with 35K visits per year. 16 bed ED, 6 bed chest pain center, 4 bed fast track. Fee-for-service, competitive salary, 401(k). Expanding patient population creating need for additional physician. MD double coverage daily, additional PA coverage weekends. Excellent backup in all specialties, stable contract since 1987. (PA 741)

*ALABAMA

Independent, democratic group seeking BC/BE emergency medicine physicians. 25,000 annual visits with 10 hours of MD double coverage daily. Employee status with partnership offered after six months. Equitable scheduling, competitive salary based on productivity, and benefits included. Located on the eastern shore of Mobile Bay. Fairhope is a progressive and growing Gulf Coast community. For inquiries or to submit a CV, contact Don Williams, MD FACEP at baymds@aol.com. (PA 784)

*CALIFORNIA

Redding. Surrounded on 3 sides by mountains and lakes, located on the Sacramento River. Democratic group staffs a 46,000+ Level II trauma, referral center as well as a community hospital within 30 miles. We offer attractive compensation and benefits, ownership potential and a balanced lifestyle opportunity. Unlimited recreational opportunities abound: water and snow skiing close by, hunt, fish, bike, boat and hike in a growing far northern California community. Contact Shasta Emergency Medical Group, Inc. PO Box 993820, Redding, CA 96099-3820. Ph 530-225-7243, Fax 530-244-4708, email: bayless@hotmail.com. (PA 750)

*COLORADO

Thriving and stable Southern Colorado Emergency Medicine group needs additional BP/BC emergency physicians for 50,000 patient ED. Work in a fast-paced, state-of-the-art Level II Trauma Center with a large referral base and great pathology. Join a democratic group which is physician owned and led and has over 25 years of experience. The group is committed to quality care and patient satisfaction. Benefits include equitable and flexible scheduling, relocation package, medical/dental/vision/short term disability, excellent pay and benefits. Full time, part time, locums available. Ask about our 18 month partnership track. Growing area on the front range of Colorado with healthy economy, great climate, low cost of living, and abundant recreational opportunities. A short drive for fishing, sailing, x-country and downhill skiing, climbing and more. Short two-hour interstate drive to Denver where you can enjoy "big city" amenities like professional sports teams and theater. Email inquiries with CV to rmiv@msn.com. (PA 778)

*ILLINOIS

Mount Sinai Hospital, primary teaching affiliate of Chicago Medical School, has full and part-time positions for EM board certified or prepared. Level I Peds and Adult Trauma Center and Fast Track with 48,000 visits. Competitive salary and benefits. Contact Leslie Zun, MD, Chairman, Department of Emergency Medicine, Mount Sinai Hospital, 15th and California, Chicago, IL 60608. Phone 773-257-6957, fax 773-257-6447 or email zunl@sinaei.org (PA 773)

*ILLINOIS

Outstanding opportunity in Rockford, IL, for ABEM (or AOBEM) certified physicians to join a well-established, top quality group in an exciting practice setting. Excellent compensation and comprehensive benefit package including the exceptional benefit of distributed ownership/equity. The practice is 58K patients/annum & growing, Level II Trauma Center & Paramedic Training Center, newly constructed state of the art ED, within department, dedicated to X-ray/CT, Fast Track, Holding and Observation Beds having a high quality nursing and support staff. Please direct inquiries and CVs to Hector Aguilera, MD, FACEP c/o Mary Schwei, Infinity HealthCare, 1035 West Glen Oak Lane, Suite 101, Mequon, WI 53092-3363. Or call 1-888-442-3883 or email mschwei@infinityhealthcare.com. (PA 779)

*IOWA

Seeking BE/BC emergency physicians. Outstanding opportunity in SE Iowa. Excellent schools, low cost of living, WORLD CLASS DEER HUNTING, live on the Mississippi River. Only 1.4 pts/hr. Package over \$280,000. Email tobyvandenbergh@hotmail.com or call 319-524-2121. (PA 781)

*IOWA

Seeking BE/BC physicians for emergency department in SE Iowa. Outstanding opportunity in SE Iowa. Excellent schools, low cost of living, WORLD CLASS DEER HUNTING, live on the Mississippi River. Only 1.4 pts/hr. Package over \$210,000. Email tobyvandenbergh@hotmail.com or call 319-524-2121. (PA 782)

*MARYLAND

Baltimore/Towson: Recruiting full-time BC/BE Emergency physician for 60k visit, suburban ED. ED group is democratic, single hospital and stable (28 years). Competitive salary, good payer mix, beautiful campus, new, state-of-the-art ED in 2004. Contact: jmwogan@gbmc.org. (PA 759)

*MINNESOTA

Minnesota, Minneapolis: The Twin Cities largest democratic, physician owned emergency medicine group seeks highly motivated board trained or board-eligible physicians to join our 100 member group. Our group staffs six community hospitals with average volumes of 40K. Base salary, benefits, and productivity and performance incentives to exceed \$350K compensation. Come see what Minneapolis has to offer other than snow. Website: www.eppanet.com (PA 747)

*MISSOURI

Kenneth Hall Regional Hospital (KRRH) located in the St. Louis, MO, Metropolitan area is currently seeking a Medical Director for its Emergency Department. KRRH is a Level II Trauma Center with a Fast Track area for urgent care and a volume of about 20,000 visits annually. Candidates should be Board Eligible/Certified in emergency medicine and preferably have previous Medical Director experience. Confidential consideration, contact Mike McManus at (618) 482-7045. Email CVs to mmcmanus@krrh.org or fax to (618) 482-7014. Website address is www.krrh.org. (PA 775)

***NEW YORK**

Full or part-time. Beth Israel Medical Center's Kings Highway Division-Midwood, Flatlands and Marine Park communities in Brooklyn, NY. Team covers 40 staff hrs/day, NP team covers 15 staff hrs/day and Emergency Medicine Residents rotate in ED and ICU. Requires BC/BE in Emergency Medicine (ABEM or AOBEM). Competitive salary and benefits. Please fax CV to M. Ognibene at 718-677-5597. EOE. (PA 748)

***NEW YORK**

Rochester, NY. Chairman-Dept. of Emergency Medicine, Unity Health System. Opportunity to lead Unity Hospital's new, state-of-the-art Emergency Center opened in February 2006 with 30 private treatment rooms and 28 Special Care Units. Required: NYS License, Board Certified/Emergency Medicine. Prior administrative leadership preferred. Demonstrated commitment to high-quality, cost effective, evidence-based care as well as hospital-wide collaboration. For consideration, send a CV to the search committee through Paula Dolan, VP -Human Resources at pdolan@unityhealth.org. (PA 780)

***NORTH CAROLINA**

Wilmington area-Stable (since 1986) and democratic emergency medicine group is seeking a full-time emergency medicine board certified/board eligible physician who is committed to providing the best emergency care in the southeastern North Carolina area. Current practice sites include a 72,000 patient/year Level II Trauma center, a 30,000 patient/year community hospital, and a 12,000 patient/year community hospital, the hospitals which we are currently recruiting for. This hospital has a new emergency department, complete with adjacent helipad, and enjoys the full support of a major regional medical center. We offer a competitive salary and comprehensive benefits. Live, practice, and enjoy a great quality of life in an exceptional coastal community with beaches, golf, and historic waterfront at your doorstep. For more information please contact J. Dale Key, dkey@ecepnet.com, or at 910-202-3363. (PA 752)

***OHIO**

Excellent Opportunity! Springfield Emergency Physicians; stable, democratic, FFS group seeks BC/BP physician. 1st year partnership. Compensation package over 300K. 44K volume ED. Pleasant work environment with competent nurses. Plans underway for new, state of the art Emergency Center to open 2010. Contact Rohn Kennington, Medical Director, 937-390-6102, email: twatsonfan@acclaimhim.com (PA 732)

***OKLAHOMA**

The University of Oklahoma College of Medicine-Tulsa is seeking a Director of Emergency Medicine Research. Responsibilities will include: directing a clinical research program in emergency medicine. Experience required: extensive teaching, peer-reviewed publications, IRB processes, biostatistics and grant applications. Oklahoma license and ABEM/AOBEM required. This position comes with a competitive salary and protected time. Appointment commensurate with experience. The University of Oklahoma is an EEO/AAE institution. Please send a letter of interest and CV to Mark A. Brandenburg, MD, Vice Chair, Department of Emergency Medicine, University of Oklahoma College of Medicine-Tulsa, 4502 E. 41st Street, Suite 2B09, Tulsa, OK 74135. mark-brandenburg@ouhsc.edu. (PA 770)

***OKLAHOMA**

Tulsa, Oklahoma - Exceptional opportunities available now for BC/BE Emergency Medicine Physicians to work in a 557-bed tertiary medical center, with a 14 bed ED (5 of those are minor care beds).
 • Level III Trauma Center • Over 50,000 visits annually • 2 teaching services in-house • Excellent Hospitalist group • 140 hrs/mo=full time • Mid-levels cover minor care. Exceptional salary/benefit package being offered, including paid malpractice and equality within group structure from day one. Tulsa, pop. 400,000, is known for its cosmopolitan flair, including a performing arts center, outdoor music festivals, and an array of shopping and restaurants. Excellent public and private school system for children, along with exceptional private universities. Tulsa also has two medical schools. For further information or consideration, please contact our Tulsa recruiter, Lori at: Toll-free: 866-396-3627. Direct line: 918-518-5460 Fax: 918-518-5461, or E-mail: lbm22@aol.com (PA 772)

***OKLAHOMA**

The University of Oklahoma College of Medicine-Tulsa is seeks faculty member with EMS and disaster expertise to direct training and research programs in EMS/disaster medicine in Oklahoma Institute of Disaster and Emergency Medicine and new EM residency program. Fellowship training is preferred. Appointment commensurate with experience. Competitive salary and protected time. Oklahoma license and ABEM/AOBEM required. The University of Oklahoma is an EEO/AAE institution. Please send a letter of interest and CV to Mark A. Brandenburg, MD, Vice Chair, Department of Emergency Medicine, University of Oklahoma College of Medicine-Tulsa, 4502 E. 41st Street, Suite 2B09, Tulsa, OK 74135. mark-brandenburg@ouhsc.edu. (PA 774)

***PENNSYLVANIA**

Faculty positions available for individual BC/BP in EM. Academic and clinical track positions available. Benefits highly competitive. Protected time for research/academic pursuits for academic track. Opportunity to work with EM residents on clinical track. Equitable scheduling. Temple University Hospital is a 600-bed tertiary care teaching hospital with a Level I Trauma Center. (PA 736)

***PENNSYLVANIA**

The Department of Emergency Medicine at Drexel University College of Medicine is conducting interviews for Program Director of Emergency Medicine. Candidate must be residency trained and board certified in Emergency Medicine. Subspecialty board certification and research experience are highly desired. The Drexel University College of Medicine carries on the fine tradition started with the first three year residency in Emergency Medicine at the Medical College of Pennsylvania (MCP) in 1971. (PA 769)

***PENNSYLVANIA**

Outstanding ED Physician Needed in State College, PA; home of Penn State University. Featuring: Independent democratic group, Fee / service, Stable, amicable relationship with administration, Volume: 44,000+, 42.5 physician hours/day, 20-22 PA hours/day, In-house dictation/transcription, Excellent nursing/ techs/ IV team, Superb admitting / consulting staff, CT/ultrasound 24/7, University community: great schools/sports/culture/without crime. E-mail Tziff@Mountnittany.org or call Sally Arnold at 814-234-6110 ext. 7850. Or mail: Theodore L. Ziff, MD FACEP, 1800 East Park Ave., State College, PA 16803. 814-234-6110. (PA 776)

***RHODE ISLAND**

Emergency Room Physician: Westerly Hospital, a pleasant seaside community located in the southwest corner of Rhode Island with 30,000 ED visits per year to our state-of-the-art Emergency Department wing, has a full-time position available for an emergency physician. Candidates must be board-certified/board-eligible in Emergency Medicine with a minimum of 2 years experience. Coastal living and a collegial atmosphere make this a great place to work. Please send CV with cover letter to M. Eddy, Medical Staff Coordinator, The Westerly Hospital, 25 Wells St., Westerly, RI, 02981. Fax 401-348-3802 or meddy@westerlyhospital.org (PA 706)

***RHODE ISLAND**

Seeking BE/BC EM MD for full-time position in beautiful Oceanside Newport, RI. Private, single-hospital, stable, democratic group. Department is 5 years new and very computerized with 32,000 census. Position offers very competitive salary and bonuses with full benefits package. Practice the full spectrum of community emergency medicine in coastal New England. (PA 783)

***SOUTH CAROLINA**

Opportunity for a BC/BE emergency medicine physician to join a highly successful ED. Level I trauma center has a volume over 100,000 visits annually. ED includes hospital wide digital PACS, ED tracking, bedside registration and EMR. The 72 bed center includes Pediatrics, Women's, Behavioral Health, Chest Pain Center, Trauma Major/Minor Care. (PA 751)

***SOUTH CAROLINA**

McLeod Regional Medical Center is seeking EM Physicians for full time employment. Competitive salary and benefits. Hospital Employee. 80+ hours of daily coverage in 8, 10, and 12 hour shifts, with additional NP hours. McLeod has 371 beds and is a Level II Trauma center. Contact Tiffany Ellington: 843-777-7000 or tellington@mcleodhealth.org. (PA 753)

***TENNESSEE**

Democratic Group seeking BC/BE emergency physicians. Two hospital contracts/100,000 patients yearly. Two year full partnership. Square schedule with nights in direct proportion to number of shifts, except first 2 yrs. 2 extra overnights per schedule, \$350.00 per extra night worked. First schedule no single coverage (night or first shift). Please contact Russ Galloway for details 615-895-1637, GAL1958@comcast.net. (PA 756)

***VIRGINIA**

Newly formed democratic group in Blue Ridge Mountains of Southwest Virginia seeks BE/BC partner. Rare opportunity to join group staffing single hospital, 36K visits, no/rare trauma. Work only 3 eight hour nights every 2-3 months, 9-10 hour shifts during day, double coverage from 10am-1am, fast-track 3p-11p 7 days, high acuity, approx 25% admissions. Same group staffing this ED for over 20 years, our ED group split off to form democratic group when the multi-specialty group of which we were formerly a part sold out to hospital. 25% profit sharing bonus first year, 50% bonus second year, then full partner, (with no buy-in) after second year. Paid malpractice, health, and LTD insurance. 2 week PTO, \$5,000 CME. Great schools, wonderful family environment, good group with which to work. ED has 24/7 availability of Radiology/Hospitalists/Forensic Nurses/Psychiatric Eval by psych caseworkers. Every MD is a partner, and all but one have been here for at least 6 years. Contact Cheryl Haas, MD at 540-529-3580 or Robert Dowling, MD at 540-529-6448, or fax your CV and letter of interest to 540-387-2459. (PA 743)

***WISCONSIN**

Full democratic group looking for a BC/BE residency trained emergency physician to join our group in central Wisconsin. We are an independent, FFS group. Outstanding compensation, full benefits and retirement package. Located in outstanding recreational area. Submit CV or to request further information contact Scott Howells, MD. (PA 735)

***AUSTRALIA**

SPECIALIST EMERGENCY MEDICINE PHYSICIANS NEEDED-We have positions available immediately for Emergency Medicine Physicians in Australia's National Capital of Canberra offering a role with professional variety and a great lifestyle. For more information, please submit CVs, or direct questions to Sue Freeman at sue@myheadhunter.com or visit our website at www.healthprofessioninternational.com. (PA 777)

ALABAMA

Alabama Gulf Coast: ABEM/AOBEM physician. Democratic Group. Partnership track. Full Employee benefits with Pension (up to \$44k). FFS arrangement. \$110/hr. Package value >\$275k. Community Hospital. New 18 bed ED. 26k volume. White sand beaches. Outdoor activities. Excellent schools. For information: John Meade, MD @ 850-380-4766 or e-mail: jmeade@statdoc.com. (PA 757)

CALIFORNIA

At Kaiser Permanente, we believe in promoting a healthier lifestyle for both our patients and our physicians. And, our world-famous weather and natural attractions make Southern California an ideal place for those who love adventure and the outdoors. Opportunities throughout Southern California. Send CV to: Kaiser Permanente, Professional Recruitment, 393 East Walnut Street, Pasadena, CA 91188-8013. Phone: (800) 541-7946. Email: David.L.Lin@kp.org. We are an AAP/EEO employer. (PA 738)

CALIFORNIA

Medical Director. Beautiful Bay Area. Medical-Legal Company based in Berkeley provides case evaluation and expert witness testimony services to law firms and insurance companies nationwide. Must be Board-Certified or eligible in Emergency Medicine. Must be personable, outgoing, and poised. Must have medical-legal and administrative experience. Flexible hours. Competitive compensation and benefits. Email cover letter, CV, letters of recommendation and salary requirements to medicolexperts@amfs.com. For additional information, please see our website: www.medicolexperts.com. (PA 768)

CALIFORNIA

Emergency Medicine Partnership
New position for BC/BP Emergency Medicine physician to join democratic, compatible group. Well-equipped hospital ER's. Low trauma volume. Medical community provides good specialty support. Enviably private practice climate with very low managed care. Competitive income, malpractice insurance, partnership and profit sharing. No urban commuting or crowding problems. Located on the coast of Northern California. Excellent schools, university and college. Spectacular scenery and stimulating cultural environment. Send CV in confidence: Sharon Mac Kenzie. macken@sonic.net (800) 735-4431 Fax: (707) 824-0146. (PA 771)

FLORIDA

Full-time BC/BE Emergency Medicine physician needed for military medical facility in Jacksonville, Florida. Level three ER with 18 patient beds, non-emergent to emergent acuity rate, and 67,000 patients/yr. Acute care clinic has 33% appointments and 67% non-emergent overflow. 160 hours per month with flexible scheduling. Competitive salary. Relocation assistance. No malpractice insurance required. Continuing Education reimbursement, 401k match, disability insurance and 26 days paid leave per year. For immediate consideration contact Nate, nparham@chesapeakectr.com. (PA 744)

KENTUCKY

St. Claire Regional a mission based hospital seeking BE/BC Emergency Medicine Physician. Eleven county service area with 30K + ED visits annually. Investment underway for new Health Education/Research facility. This university town is found near Cave Run Lake. Competitive salary/benefit package. Submit CV's to: ambaker@st-claire.org (PA 754)

NEW YORK

Emergency room staff physician BC/BE in Emergency Medicine. Excellent salary & benefit package. Please call for more information (914-944-8313). Please submit CV to apply@executivehealthsearch.com. (PA 763)

TEXAS

Texas A&M University System, Health Science Center. Full time emergency medicine faculty positions available in Corpus Christi, Texas. Outstanding opportunity for academic career oriented individuals. Protected academic time for research and interaction with residents and medical students. Excellent clinical environment in high acuity emergency department of regional tertiary facility. Academic appointment commensurate with experience. Superb remuneration and benefits package. Candidates must be board certified/board prepared in emergency medicine. Responsibilities included teaching and clinical supervision of rotating residents. An application for an EM residency has been submitted to the ACGME. Corpus Christi is a coastal paradise where recreational opportunities abound. For further information please contact Bel Flores at 2626 Hospital Blvd. 3W, Corpus Christi, Texas, 78405 or call 361-902-6570. (PA 762)

VIRGINIA

Lynchburg - Stable, Democratic Group. Level II Trauma, 75K visits, single hospital/ED. 18 member group. 8 hour shifts plus fast track. Competitive: Salary, retirement, CME, Mal-practice, medical. One or two FTE's if qualified. Flexible start date. (PA 734)

WASHINGTON

Clarkston. Democratic, small, single hospital group needs full timer for 14K visits/yr ED. Non-trauma emphasis. Some state of the art amenities. Hospitalist service starting now, and new ED soon. Beautiful rural region where grassland meets Rocky Mountain foothills. Close to skiing, water sports, fishing-many types of outdoor fun. Boarding required in EM or Board Eligible. Partnership track. Contact Kurt Martyn MD kurtm@moscow.com or 509-758-4665. (PA 745)

WASHINGTON

Emergency Medicine Physician Board Certified/Residency trained in emergency medicine. Madigan Army Medical Center, Ft. Lewis, Washington. Part-time/Full-time positions available. Any state license accepted. Medical Malpractice included. Please reply to Betsy Weixel at blw@americanhospital.us. (PA 749)

WASHINGTON

Full-time BC/EM physician to work as an independent contractor with the PhyAmerica Government Services, Inc. at Naval Hospital Bremerton, WA. No WA state license required. Work 40 hours per week. Contact Ruby Mangum 1-800-476-4157 ext. 4645 rmangum@phyamerica.com. (PA 766)

WASHINGTON

Washington, Kitsap Peninsula: We staff two brand-new EDs seeing a total of 60,000 pts/annually and seek a full-time BC EM Physician to expand coverage. Established, progressive, democratic group with excellent compensation and benefit package. Mountain and Ocean recreation opportunities abound. One-hour ferry ride to Seattle. See Website: www.harrisonmedical.org Email CV to: Gail Donovan at gdonovan@harrisonmedical.org. (PA 765)

WISCONSIN

Green Bay, WI – Full time opportunity for 1-2 board certified EM physicians. We offer a democratic, independent, FFS Group. 28,000/year visits with 14-16 hours/day of MP, PA or MD double coverage. Level III ED. Certified Heart Center and Stroke Center. Excellent pay & full benefits. (PA 758)

SAUDI ARABIA

This JCIA accredited hospital has an ED volume of 45,000 annually, 75% which are tertiary care. All shifts (8 hours) are triple coverage. Seeing a culture "from the inside" is a wonderful experience, and will change the way you see the world. Travel and accommodation will be provided for locums as well as permanent staff. If interested contact Hisham Alomran, MD, MPH, halomran@kfsshr.edu.sa. (PA 739)

Urgent Care Practice For Sale

FLORIDA

Do you dream of running your own business and living 2 minutes away on the beach? Established and growing urgent care practice with affluent patients (70% insurance/30% cash/0 no pay!) near beach generating \$700,000 in annual revenue with \$300,000 expenses [employees (including full-time physician assistant and part-time nurse practitioner), rent, utilities, supplies, and insurance]. PA/NP covers 160 hours per month, you manage and work 44 clinical hours per month (decrease PA/NP coverage, increase physician clinical time, and decrease annual expenses by \$100,000)]. 1860 sq. ft. furnished condo [living room, kitchen, 3 bedrooms, 2 new bathrooms with whirlpool large bathtub/steam room, and deck overlooking ocean and 5 miles of beautiful beach plus pool/whirlpool/exercise room/party room]. Package price to live and work in paradise - \$2.1 million. Call 863.698.1228. (PA 755)



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14th Annual Scientific Assembly



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